

Facility Name & ID Number Batavia Rehabilitation & Health Care Center

0047399 Report Period Beginning: 01/01/2006 Ending: 12/31/2006

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	
	Skilled (SNF)			1
	Skilled Pediatric (SNF/PED)			2
63	Intermediate (ICF)	63	22,995	3
	Intermediate/DD			4
	Sheltered Care (SC)			5
	ICF/DD 16 or Less			6
63	TOTALS	63	22,995	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				
	2 Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8 SNF					8
9 SNF/PED					9
10 ICF	13,070	2,819		15,889	10
11 ICF/DD					11
12 SC					12
13 DD 16 OR LESS					13
14 TOTALS	13,070	2,819		15,889	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 69.10%

D. How many bed-hold days during this year were paid by the Department? 0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES NO Non-allowable costs have been eliminated in Schedule V, Column 7.

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES NO

I. On what date did you start providing long term care at this location?
Date started 10/01/2005

J. Was the facility purchased or leased after January 1, 1978?
YES Date 10/01/2005 NO

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

Medicare Intermediary N/A

IV. ACCOUNTING BASIS

ACCUAL MODIFIED CASH* CASH*

Is your fiscal year identical to your tax year? YES NO

Tax Year: 12/31/2006 Fiscal Year: 12/31/2006

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number **Batavia Rehabilitation & Health Care Center** # **0047399** Report Period Beginning: **01/01/2006** Ending: **12/31/2006**

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 OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
A. General Services											
1	Dietary	114,110	9,171	3,780	127,061		127,061	1,579	128,640		1
2	Food Purchase		55,630		55,630		55,630	(5,422)	50,208		2
3	Housekeeping	74,466	13,303		87,769		87,769	51	87,820		3
4	Laundry	18,608	3,762		22,370		22,370		22,370		4
5	Heat and Other Utilities			49,299	49,299		49,299	210	49,509		5
6	Maintenance	28,543	13,673	9,167	51,383		51,383	3,914	55,297		6
7	Other (specify):* Home Office Benefits							984	984		7
8	TOTAL General Services	235,727	95,539	62,246	393,512		393,512	1,316	394,828		8
B. Health Care and Programs											
9	Medical Director			5,400	5,400		5,400		5,400		9
10	Nursing and Medical Records	758,597	28,490	28,624	815,711		815,711	4,876	820,587		10
10a	Therapy			1,982	1,982		1,982	375	2,357		10a
11	Activities	27,351	315	423	28,089		28,089		28,089		11
12	Social Services	27,782	146		27,928		27,928		27,928		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* Home Office Benefits							1,534	1,534		15
16	TOTAL Health Care and Programs	813,730	28,951	36,429	879,110		879,110	6,785	885,895		16
C. General Administration											
17	Administrative	61,851		36,500	98,351		98,351	(24,421)	73,930		17
18	Directors Fees										18
19	Professional Services			1,362	1,362		1,362	6,919	8,281		19
20	Dues, Fees, Subscriptions & Promotions			6,031	6,031		6,031	778	6,809		20
21	Clerical & General Office Expenses	28,512	4,672	9,900	43,084		43,084	21,940	65,024		21
22	Employee Benefits & Payroll Taxes			172,893	172,893		172,893	2,845	175,738		22
23	Inservice Training & Education			6	6		6	145	151		23
24	Travel and Seminar							584	584		24
25	Other Admin. Staff Transportation			2,692	2,692		2,692	1,713	4,405		25
26	Insurance-Prop.Liab.Malpractice			11,993	11,993		11,993	895	12,888		26
27	Other (specify):* Home Office Benefits							4,372	4,372		27
28	TOTAL General Administration	90,363	4,672	241,377	336,412		336,412	15,770	352,182		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,139,820	129,162	340,052	1,609,034		1,609,034	23,871	1,632,905		29

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

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

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7**	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
30	D. Ownership			6,401	6,401		6,401	5,825	12,226			30
31	Depreciation											31
32	Amortization of Pre-Op. & Org.											32
33	Interest			12,491	12,491		12,491	13,495	25,986			33
34	Real Estate Taxes			38,120	38,120		38,120	1,570	39,690			34
35	Rent-Facility & Grounds							715	715			35
36	Rent-Equipment & Vehicles			4,431	4,431		4,431	468	4,899			36
37	Other (specify):*											37
	TOTAL Ownership			61,443	61,443		61,443	22,073	83,516			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		441		441		441		441			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			34,493	34,493		34,493		34,493			42
43	Other (specify):* Nonallowable Cost			13,258	13,258		13,258	(13,258)				43
44	TOTAL Special Cost Centers		441	47,751	48,192		48,192	(13,258)	34,934			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,139,820	129,603	449,246	1,718,669		1,718,669	32,686	1,751,355			45

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

VI. ADJUSTMENT DETAIL

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

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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(2,284)	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	533	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(272)	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	(435)	43		18
19	Entertainment				19
20	Contributions	(166)	43		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(6,178)	43		24
25	Fund Raising, Advertising and Promotional	(1,985)	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 PG5A	(12,156)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (22,943)		\$	30

BHF USE ONLY							
48		49		50		51	
						52	

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	55,629		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 55,629		36
	(sum of SUBTOTALS)			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ 32,686		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.

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

SEE ACCOUNTANTS' COMPILATION REPORT

Batavia Rehabilitation & Health Care Center

ID# 0047399

Report Period Beginning: 01/01/2006

Ending: 12/31/2006

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Nonallowable special events	\$ (1,938)	43	1
2	Offset Vending Revenue	(169)	2	2
3	Offset Meal Revenue	(2,466)	2	3
4	Offset Miscellaneous Revenue	(123)	21	4
5	Offset Interest Income	(2,823)	32	5
6	Offset Home Office Architect Fees	(455)	21	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	(7,974)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Batavia Rehabilitation & Health Care Center# 0047399 Report Period Beginning:01/01/2006Ending: 12/31/2006

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	1,130	0	448	0	0	0	0	0	0	0	1,578	1
2	Food Purchase	(2,635)	56	0	3	0	0	0	0	0	0	0	(2,576)	2
3	Housekeeping	0	50	0	1	0	0	0	0	0	0	0	51	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	210	0	0	0	0	0	0	0	0	0	210	5
6	Maintenance	0	2,873	0	1,041	0	0	0	0	0	0	0	3,914	6
7	Other (specify):*	0	453	0	531	0	0	0	0	0	0	0	984	7
8	TOTAL General Services	(2,635)	4,772	0	2,024	0	4,161	8						
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	4,085	0	791	0	0	0	0	0	0	0	4,876	10
10a	Therapy	0	375	0	0	0	0	0	0	0	0	0	375	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	1,263	0	271	0	0	0	0	0	0	0	1,534	15
16	TOTAL Health Care and Programs	0	5,723	0	1,062	0	6,785	16						
	C. General Administration													
17	Administrative	0	(25,363)	0	943	0	0	0	0	0	0	0	(24,420)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	4,877	0	2,042	0	0	0	0	0	0	0	6,919	19
20	Fees, Subscriptions & Promotions	0	478	0	300	0	0	0	0	0	0	0	778	20
21	Clerical & General Office Expenses	(578)	0	17,951	4,566	0	0	0	0	0	0	0	21,939	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	145	0	0	0	0	0	0	0	0	145	23
24	Travel and Seminar	0	0	4,347	419	0	0	0	0	0	0	0	4,766	24
25	Other Admin. Staff Transportation	0	0	1,156	557	0	0	0	0	0	0	0	1,713	25
26	Insurance-Prop.Liab.Malpractice	0	0	855	40	0	0	0	0	0	0	0	895	26
27	Other (specify):*	0	0	3,173	1,199	0	0	0	0	0	0	0	4,372	27
28	TOTAL General Administration	(578)	(20,008)	27,627	10,066	0	17,107	28						
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(3,213)	(9,513)	27,627	13,152	0	28,053	29						

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Batavia Rehabilitation & Health Care Center# 0047399

Report Period Beginning:

01/01/2006 Ending:12/31/2006

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	533	0	4,426	866	0	0	0	0	0	0	0	5,825	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(2,823)	0	2,458	13,860	0	0	0	0	0	0	0	13,495	32
33	Real Estate Taxes	0	0	519	1,051	0	0	0	0	0	0	0	1,570	33
34	Rent-Facility & Grounds	0	0	503	212	0	0	0	0	0	0	0	715	34
35	Rent-Equipment & Vehicles	0	0	264	204	0	0	0	0	0	0	0	468	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(2,290)	0	8,170	16,193	0	22,073	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):*	(13,258)	0	0	0	0	0	0	0	0	0	0	(13,258)	43
44	TOTAL Special Cost Centers	(13,258)	0	0	0	0	0	0	0	0	0	0	(13,258)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(18,761)	(9,513)	35,797	29,345	0	36,868	45						

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Mark Petersen		See Attached Schedule 6A		See Attached Schedule 6A		

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: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V	1 Dietary	\$	Petersen Health Care, Inc.	100.00%	\$ 1,130	\$	1,130 1
2	V	2 Food		Petersen Health Care, Inc.	100.00%	56		56 2
3	V	3 Housekeeping		Petersen Health Care, Inc.	100.00%	50		50 3
4	V	4 Laundry		Petersen Health Care, Inc.	100.00%			
5	V	5 Utilities		Petersen Health Care, Inc.	100.00%	210		210 5
6	V	6 Maintenance		Petersen Health Care, Inc.	100.00%	2,873		2,873 6
7	V	7 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	453		453 7
8	V	10 Nursing and Medical Records		Petersen Health Care, Inc.	100.00%	4,085		4,085 8
9	V	10A Therapy		Petersen Health Care, Inc.	100.00%	375		375 9
10	V	15 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	1,263		1,263 10
11	V	17 Administrative	36,500	Petersen Health Care, Inc.	100.00%	11,137		(25,363) 11
12	V	19 Professional Services		Petersen Health Care, Inc.	100.00%	4,877		4,877 12
13	V	20 Due, Fees, Subs & Promos		Petersen Health Care, Inc.	100.00%	478		478 13
14	Total		\$ 36,500			\$ 26,987	\$ *	(9,513) 14

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

SEE ACCOUNTANTS' COMPILATION REPORT

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	21 Clerical & General Office	\$	Petersen Health Care, Inc.	100.00%	\$ 17,951	\$ 17,951
16	V	23 Inservice Training & Education		Petersen Health Care, Inc.	100.00%	145	145
17	V	24 Travel and Seminar		Petersen Health Care, Inc.	100.00%	4,347	4,347
18	V	25 Other Admin. Staff Transport		Petersen Health Care, Inc.	100.00%	1,156	1,156
19	V	26 Insurance-Prop.Liab.Malpractice		Petersen Health Care, Inc.	100.00%	855	855
20	V	27 Mgmt Allocation of Benefits		Petersen Health Care, Inc.	100.00%	3,173	3,173
21	V	30 Depreciation		Petersen Health Care, Inc.	100.00%	4,426	4,426
22	V	32 Interest		Petersen Health Care, Inc.	100.00%	2,458	2,458
23	V	33 Real Estate Taxes		Petersen Health Care, Inc.	100.00%	519	519
24	V	34 Rent - Facility & Grounds		Petersen Health Care, Inc.	100.00%	503	503
25	V	35 Rent - Equipment & Vehicles		Petersen Health Care, Inc.	100.00%	264	264
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$			\$ 35,797	\$ * 35,797

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

SEE ACCOUNTANTS' COMPILATION REPORT

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, Inc.	100.00%	\$ 448	\$ 448
16	V	2 Food		Petersen Health Care, Inc.	100.00%	3	3
17	V	3 Housekeeping		Petersen Health Care, Inc.	100.00%	1	1
18	V	6 Maintenance		Petersen Health Care, Inc.	100.00%	1,041	1,041
19	V	7 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	531	531
20	V	10 Nursing and Medical Records		Petersen Health Care, Inc.	100.00%	791	791
21	V	15 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	271	271
22	V	17 Administrative		Petersen Health Care, Inc.	100.00%	943	943
23	V	19 Professional Services		Petersen Health Care, Inc.	100.00%	2,042	2,042
24	V	20 Due, Fees, Subs & Promos		Petersen Health Care, Inc.	100.00%	300	300
25	V	21 Clerical & General Office		Petersen Health Care, Inc.	100.00%	4,566	4,566
26	V	24 Travel & Seminar		Petersen Health Care, Inc.	100.00%	419	419
27	V	25 Other Admin. Staff Transport		Petersen Health Care, Inc.	100.00%	557	557
28	V	26 Insurance-Prop.Liab.Malpractice		Petersen Health Care, Inc.	100.00%	40	40
29	V	27 Mgmt Allocation of Benefits		Petersen Health Care, Inc.	100.00%	1,199	1,199
30	V	30 Depreciation		Petersen Health Care, Inc.	100.00%	866	866
31	V	32 Interest		Petersen Health Care, Inc.	100.00%	13,860	13,860
32	V	33 Real Estate Taxes		Petersen Health Care, Inc.	100.00%	1,051	1,051
33	V	34 Rent - Facility & Grounds		Petersen Health Care, Inc.	100.00%	212	212
34	V	35 Rent - Equipment & Vehicles		Petersen Health Care, Inc.	100.00%	204	204
35	V						
36	V						
37	V						
38	V						
39	Total		\$			\$ 29,345	\$ * 29,345

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Batavia Rehabilitation & Health Care Cent # 0047399 Report Period Beginning: 01/01/2006 Ending: 12/31/2006

VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Mark Petersen	President	Administrative	100.00	See Schedule 7A	0.7	1.39	Salary	\$ 11,135	L17,C7	1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 11,135		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.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Batavia Rehabilitation & Health Care Center # 0047399 Report Period Beginning: 01/01/2006 Ending: 2/31/2006

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 West 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	Patient Days	56	\$ 81,179	\$ 80,967	15,889	\$ 1,130	1
2	2	Food	Patient Days	56	3,989	0	15,889	56	2
3	3	Housekeeping	Patient Days	56	3,589	0	15,889	50	3
4	4	Laundry	Patient Days	56	0	0	15,889	0	4
5	5	Utilities	Patient Days	56	15,054	0	15,889	210	5
6	6	Maintenance	Patient Days	56	206,416	110,513	15,889	2,873	6
7	7	Mgmt. Allocation of Benefits	Patient Days	56	32,526	0	15,889	453	7
8	10	Nursing and Medical Records	Patient Days	56	293,462	289,197	15,889	4,085	8
9	10A	Therapy	Patient Days	56	26,945	0	15,889	375	9
10	15	Mgmt. Allocation of Benefits	Patient Days	56	90,724	0	15,889	1,263	10
11	17	Administrative	Patient Days	56	800,000	800,000	15,889	11,137	11
12	19	Professional Services	Patient Days	56	350,361	4,303	15,889	4,877	12
13	20	Due, Fees, Subs & Promos	Patient Days	56	34,325	0	15,889	478	13
14	21	Clerical & General Office	Patient Days	56	1,289,623	954,322	15,889	17,951	14
15	23	Inservice Training & Education	Patient Days	56	10,426	0	15,889	145	15
16	24	Travel and Seminar	Patient Days	56	312,259	0	15,889	4,347	16
17	25	Other Admin. Staff Transport	Patient Days	56	83,062	0	15,889	1,156	17
18	26	Insurance-Prop.Liab.Malpractice	Patient Days	56	61,457	0	15,889	855	18
19	27	Mgmt Allocation of Benefits	Patient Days	56	227,912	0	15,889	3,173	19
20	30	Depreciation	Patient Days	56	317,964	0	15,889	4,426	20
21	32	Interest	Patient Days	56	176,614	0	15,889	2,458	21
22	33	Real Estate Taxes	Patient Days	56	37,282	0	15,889	519	22
23	34	Rent - Facility & Grounds	Patient Days	56	36,133	0	15,889	503	23
24	35	Rent - Equipment & Vehicles	Patient Days	56	18,933	0	15,889	264	24
25	TOTALS				\$ 4,510,235	\$ 2,239,302		\$ 62,784	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Batavia Rehabilitation & Health Care Center # 0047399 Report Period Beginning: 01/01/2006 Ending: 2/31/2006

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 West 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	Patient Days	46	\$ 12,081	\$ 11,958	15,889	\$ 448	1
2	2	Food	Patient Days	46	93		15,889	3	2
3	3	Housekeeping	Patient Days	46	28		15,889	1	3
4	4	Laundry	Patient Days	46			15,889		4
5	5	Utilities	Patient Days	46			15,889		5
6	6	Maintenance	Patient Days	46	28,012	28,012	15,889	1,041	6
7	7	Mgmt. Allocation of Benefits	Patient Days	46	14,282		15,889	531	7
8	10	Nursing and Medical Records	Patient Days	46	21,299	20,434	15,889	791	8
9	10A	Therapy	Patient Days	46			15,889		9
10	15	Mgmt. Allocation of Benefits	Patient Days	46	7,301		15,889	271	10
11	17	Administrative	Patient Days	46	25,391	25,391	15,889	943	11
12	19	Professional Services	Patient Days	46	54,971		15,889	2,042	12
13	20	Due, Fees, Subs & Promos	Patient Days	46	8,088		15,889	300	13
14	21	Clerical & General Office	Patient Days	46	122,893	64,907	15,889	4,566	14
15	23	Inservice Training & Education	Patient Days	46			15,889		15
16	24	Travel and Seminar	Patient Days	46	11,280		15,889	419	16
17	25	Other Admin. Staff Transport	Patient Days	46	15,003		15,889	557	17
18	26	Insurance-Prop.Liab.Malpractice	Patient Days	46	1,087		15,889	40	18
19	27	Mgmt Allocation of Benefits	Patient Days	46	32,265		15,889	1,199	19
20	30	Depreciation	Patient Days	46	23,301		15,889	866	20
21	32	Interest	Patient Days	46	373,049		15,889	13,860	21
22	33	Real Estate Taxes	Patient Days	46	28,282		15,889	1,051	22
23	34	Rent - Facility & Grounds	Patient Days	46	5,700		15,889	212	23
24	35	Rent - Equipment & Vehicles	Patient Days	46	5,479		15,889	204	24
25	TOTALS				\$ 789,885	\$ 150,702		\$ 29,345	25

SEE ACCOUNTANTS' COMPILATION REPORT

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										
										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	LaSalle Bank		X	Mortgage	Varies	09/30/05	\$ 110,000	\$ 108,394	09/20/10	Varies	\$ 10,567	1							
2	Ziegler Healthcare		X	Mortgage	\$639.08	11/22/04	33,217	19,963	11/17/09	0.0590	1,924	2							
3												3							
4							Interest income offset				(2,823)	4							
5							Allocated from Home Office				16,318	5							
Working Capital																			
6												6							
7												7							
8												8							
9	TOTAL Facility Related				\$639.08		\$ 143,217	\$ 128,357			\$ 25,986	9							
B. Non-Facility Related*																			
10												10							
11												11							
12												12							
13												13							
14	TOTAL Non-Facility Related						\$	\$			\$	14							
15	TOTALS (line 9+line14)						\$ 143,217	\$ 128,357			\$ 25,986	15							

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

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

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

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2005 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2005 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2005.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2005 real estate tax bill to Healthcare and Family Services, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2006 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2005 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Batavia Rehabilitation & Health Care Center COUNTY Kane

FACILITY IDPH LICENSE NUMBER 0047399

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 2005 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 2005.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>06-100-14-00</u>	<u>Nursing Home</u>	\$ <u>38,120.62</u>	\$ <u>38,120.62</u>
2. _____	<u>Home Office</u>	\$ _____	\$ <u>1,570.00</u>
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>38,120.62</u>	\$ <u>39,690.62</u>

B. Real Estate Tax Cost Allocations

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

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

C. Tax Bills

Attach a copy of the original 2005 tax bills which were listed in Section A to this statement. Be sure to use the 2005 tax bill which is normally paid during 2006.

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.

SEE ACCOUNTANTS' COMPILATION REPORT

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 14,290 B. General Construction Type: Exterior BRICK Frame WOOD 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).

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: N/A 2. Number of Years Over Which it is Being Amortized: N/A
 3. Current Period Amortization: N/A 4. Dates Incurred: N/A

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

XI. OWNERSHIP COSTS:

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1	Facility	79,279	2005	\$ 110,500	1
2					2
3	TOTALS	79,279		\$ 110,500	3

SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)

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

	1	FOR BHF USE ONLY	2	3	4	5	6	7	8	9	
	Beds*		Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	63		2005	1972	\$ ***	\$		\$	\$	\$	4
5											5
6	Allocation										6
7	From Home			2006	9,476			415	415	415	7
8	Office										8
	Improvement Type**										
9	Tile			2005	8,119	325	20	406	81		9
10	Sidewalks			2006	14,105	235	15	470	235		10
11	Roof			2006	18,900		10	945	945		11
12	Land Improvement Booked			2006		235			(235)		12
13	Building Booked			2006							13
14	Building Improvement Booked			2006		693			(693)	2,024	14
15											15
16	Home Office allocations - land improvements				548			51	51	51	16
17	Home Office allocations - leasehold				15			1	1	1	17
18											18
19											19
20											20
21	*** Note:										21
22	Facility was purchased as part of a multi-facility										22
23	sale. For purposes of allocating the purchase										23
24	price, appraisers valued the building and land										24
25	at the value of the bare land, only. The allocated										25
26	amount appears on page 11 (Sch. XI (A) line 1, column 4.										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
SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9					
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation					
37		\$	\$		\$	\$	\$	37				
38								38				
39								39				
40								40				
41								41				
42								42				
43								43				
44								44				
45								45				
46								46				
47								47				
48								48				
49								49				
50								50				
51								51				
52								52				
53								53				
54								54				
55								55				
56								56				
57								57				
58								58				
59								59				
60								60				
61								61				
62								62				
63								63				
64								64				
65								65				
66								66				
67								67				
68								68				
69								69				
70	TOTAL (lines 4 thru 69)	\$	51,163	\$	1,488	\$	2,288	\$	800	\$	2,491	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 24,505	\$ 4,366	\$ 4,346	\$ (20)	3-7	\$ 6,518	71
72	Current Year Purchases	10,335	782	767	(15)	5-20	768	72
73	Fully Depreciated Assets							73
74	Allocation from Home Office			4,825	4,825			74
75	TOTALS	\$ 34,840	\$ 5,148	\$ 9,938	\$ 4,790		\$ 7,286	75

D. Vehicle Depreciation (See instructions.)*

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

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 196,503	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 6,636	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 12,226	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 5,590	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 9,777	85

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

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

G. Construction-in-Progress

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Batavia Rehabilitation & Health Care Center

0047399

Report Period Beginning: 01/01/2006

Ending: 12/31/2006

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	Other: Home Office Allocation				715			5
6								6
7	TOTAL				\$ 715			7

**

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

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

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

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

15. Is Movable equipment rental included in building rental?

YES NO

16. Rental Amount for movable equipment: \$ 4,899 Description: Copier - \$2,674; Dishwasher - \$590; Storage Unit - \$140; Home Office - \$468; Nursing Equip \$1027

(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	N/A		\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

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

Fiscal Year Ending Annual Rent

12. /2007 \$ _____

13. /2008 \$ _____

14. /2009 \$ _____

* 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.

SEE ACCOUNTANTS' COMPILATION REPORT

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? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>It is the policy of this facility to only hire certified nurses aides. If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. CLASSROOM PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. CLINICAL PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
---	--	---

B. EXPENSES

ALLOCATION OF COSTS (d)

	Facility			
	1	2	3	4
	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.
- SEE ACCOUNTANTS' COMPILATION REPORT

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

1	Service	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	5					
					Units	Cost				
1	Licensed Occupational Therapist	10A(3)	hrs	\$	9	\$ 710	\$	9	\$ 710	1
2	Licensed Speech and Language Development Therapist	10A(3)	hrs		2	181		2	181	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A(3),(7)	hrs		14	1,091	375	14	1,466	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				128		128	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): <u>Oxygen</u>	39(2)					313		313	13
14	TOTAL			\$	25	\$ 1,982	\$ 816	25	\$ 2,798	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.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Batavia Rehabilitation & Health Care Center

0047399

Report Period Beginning: 01/01/2006

Ending:

12/31/2006

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2006

(last day of reporting year)

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

	1	2	
	Operating	After Consolidation*	
A. Current Assets			
1 Cash on Hand and in Banks	\$ 575	\$ 575	1
2 Cash-Patient Deposits			2
3 Accounts & Short-Term Notes Receivable-Patients (less allowance -0-)	280,228	280,228	3
4 Supply Inventory (priced at)			4
5 Short-Term Investments			5
6 Prepaid Insurance			6
7 Other Prepaid Expenses	4,760	4,760	7
8 Accounts Receivable (owners or related parties)	2,586	2,586	8
9 Other(specify):			9
TOTAL Current Assets (sum of lines 1 thru 9)	\$ 288,149	\$ 288,149	10
B. Long-Term Assets			
11 Long-Term Notes Receivable			11
12 Long-Term Investments			12
13 Land	124,606	110,500	13
14 Buildings, at Historical Cost	27,019	51,163	14
15 Leasehold Improvements, at Historical Cos			15
16 Equipment, at Historical Cost	34,840	34,840	16
17 Accumulated Depreciation (book methods)	(6,828)	(9,777)	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
TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 179,637	\$ 186,726	24
TOTAL ASSETS (sum of lines 10 and 24)	\$ 467,786	\$ 474,875	25

	1	2	
	Operating	After Consolidation*	
C. Current Liabilities			
26 Accounts Payable	\$ 284,262	\$ 284,262	26
27 Officer's Accounts Payable			27
28 Accounts Payable-Patient Deposits			28
29 Short-Term Notes Payable			29
30 Accrued Salaries Payable	21,977	21,977	30
31 Accrued Taxes Payable (excluding real estate taxes)	10,629	10,629	31
32 Accrued Real Estate Taxes(Sch.IX-B)	38,120	38,120	32
33 Accrued Interest Payable	1,332	1,332	33
34 Deferred Compensation			34
35 Federal and State Income Taxes			35
Other Current Liabilities(specify):			
36 <u>Accrued Expenses</u>	11,255	11,255	36
37			37
TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 367,575	\$ 367,575	38
D. Long-Term Liabilities			
39 Long-Term Notes Payable			39
40 Mortgage Payable	19,963	19,963	40
41 Bonds Payable	108,394	108,394	41
42 Deferred Compensation			42
Other Long-Term Liabilities(specify):			
43			43
44			44
TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 128,357	\$ 128,357	45
TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 495,932	\$ 495,932	46
47 TOTAL EQUITY (page 18, line 24)	\$ (28,146)	\$ (21,057)	47
TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 467,786	\$ 474,875	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 23,340	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 23,340	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(51,486)	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)	\$ (51,486)	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)	\$ (28,146)	24 *

Operating Entity Only

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

1

Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 1,661,602	1
2	Discounts and Allowances for all Levels		2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 1,661,602	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	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	2,466	14
15	Telephone, Television and Radic		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 2,466	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	2,823	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 2,823	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Vending/Misc</u>	292	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 292	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 1,667,183	30

2

Expenses		Amount	
A. Operating Expenses			
31	General Services	393,512	31
32	Health Care	879,110	32
33	General Administration	336,412	33
B. Capital Expense			
34	Ownership	61,443	34
C. Ancillary Expense			
35	Special Cost Centers	13,699	35
36	Provider Participation Fee	34,493	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 1,718,669	40
41	Income before Income Taxes (line 30 minus line 40)**	(51,486)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (51,486)	43

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? No If not, please attach a reconciliation. Entity is a cash basis taxpayer

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

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

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	2,199	2,199	\$ 69,038	\$ 31.40	1
2	Assistant Director of Nursing		0			2
3	Registered Nurses	9,334	9,334	231,606	24.81	3
4	Licensed Practical Nurses	4,282	4,288	117,902	27.50	4
5	CNAs & Orderlies	25,141	25,305	312,316	12.34	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,037	2,045	27,351	13.37	9
10	Activity Assistants					10
11	Social Service Workers	2,072	2,072	27,782	13.41	11
12	Dietician					12
13	Food Service Supervisor	2,080	2,080	34,667	16.67	13
14	Head Cook					14
15	Cook Helpers/Assistants	6,634	6,666	79,443	11.92	15
16	Dishwashers					16
17	Maintenance Workers	1,874	1,914	28,543	14.91	17
18	Housekeepers	7,765	7,765	74,466	9.59	18
19	Laundry	1,725	1,725	18,608	10.79	19
20	Administrator	1,229	1,229	61,851	50.31	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	3,726	3,776	28,512	7.55	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 Cr: CPC	1,163	1,163	27,735	23.86	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	71,261	71,561	\$ 1,139,820 *	\$ 15.93	34

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	72	\$ 3,780	1,3	35
36	Medical Director	Monthly	5,400	9,3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	1,067	10,3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	72	\$ 10,247		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	252	\$ 13,383	10,3	50
51	Licensed Practical Nurses	274	13,758	10,3	51
52	Certified Nurse Assistants/Aides	16	416	10,3	52
53	TOTAL (lines 50 - 52)	542	\$ 27,557		53

SEE ACCOUNTANTS' COMPILATION REPORT

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

** See instructions.

Petersen Health Care, Inc. (Batavia Rehab & Health Care Cntr)
Provider Number - 0047399
FYE: 12/31/2006

Schedule 21A

XIX. SUPPORT SCHEDULE

C. Professional Services

Total (agree to Schedule V, line 19, column 3) 1,362

Allocated from Home Office

Other Professional Fees - PHC 4,812

Legal - PHC 65

Other Professional Fees - PHO 1,981

Legal - PHO 61

Total (agree to Schedule V, line 19, column 8) 8,281

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	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009	FY2010	FY2011
1	N/A	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2												
3												
4												
5												
6												
7												
8												
9												
10												
11												
12												
13												
14												
15												
16												
17												
18												
19												
20	TOTALS	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Batavia Rehabilitation & Health Care Center# 0047399Report Period Beginning: 01/01/2006Ending: 12/31/2006**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 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? 12 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 9,393 Line 10,2
- (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. \$ 34,493
This amount is to be recorded on line 42 of Schedule V
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions
- (15) Indicate the cost of employee meals that has been reclassified to employee benefit on Schedule V. \$ 2,845 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 2,466
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
c. What percent of all travel expense relates to transportation of nurses and patients? N/A
d. Have vehicle usage logs been maintained? Adequate records have been maintained.
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? No
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? Yes
Firm Name: Ginoli & Co The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? No If no, please explain. Audit currently in progress
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? N/A
Attach invoices and a summary of services for all architect and appraisal fees.

SEE ACCOUNTANTS' COMPILATION REPORT