

Facility Name & ID Number Flora Rehabilitation & Health Care Center

0046615 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	
1	<u>32</u>	Skilled (SNF)	<u>32</u>	<u>11,680</u>	1
2		Skilled Pediatric (SNF/PED)			2
3	<u>67</u>	Intermediate (ICF)	<u>67</u>	<u>24,455</u>	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>99</u>	TOTALS	<u>99</u>	<u>36,135</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other		Total
8	SNF			<u>6,313</u>	<u>6,313</u>	8
9	SNF/PED					9
10	ICF	<u>20,687</u>	<u>6,102</u>		<u>26,789</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>20,687</u>	<u>6,102</u>	<u>6,313</u>	<u>33,102</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 91.61%

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 12/17/2004

J. Was the facility purchased or leased after January 1, 1978?

YES Date 12/17/2004 NO

K. Was the facility certified for Medicare during the reporting year?

YES NO If YES, enter number

of beds certified 32 and days of care provided 6,313

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

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

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

Facility Name & ID Number Flora Rehabilitation & Health Care Center # 0046615 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	170,964	22,451	9,495	202,910		202,910	1,999	204,909		
2	Food Purchase		157,676		157,676		157,676	(8,697)	148,979		
3	Housekeeping	102,765	24,805		127,570		127,570	84	127,654		
4	Laundry	41,835	16,656		58,491		58,491		58,491		
5	Heat and Other Utilities			97,936	97,936		97,936	353	98,289		
6	Maintenance	37,505	34,743	4,394	76,642		76,642	4,844	81,486		
7	Other (specify):* Home Office Benefits							763	763		
8	TOTAL General Services	353,069	256,331	111,825	721,225		721,225	(654)	720,571		
	B. Health Care and Programs										
9	Medical Director			31,039	31,039		31,039		31,039		
10	Nursing and Medical Records	1,367,321	233,703	1,829	1,602,853		1,602,853	4,620	1,607,473		
10a	Therapy	242,855		60,289	303,144		303,144	632	303,776		
11	Activities	32,117	7,756	8,672	48,545		48,545		48,545		
12	Social Services	56,687			56,687		56,687		56,687		
13	CNA Training										
14	Program Transportation										
15	Other (specify):* Home Office Benefits							2,129	2,129		
16	TOTAL Health Care and Programs	1,698,980	241,459	101,829	2,042,268		2,042,268	7,381	2,049,649		
	C. General Administration										
17	Administrative	55,133		175,000	230,133		230,133	(156,225)	73,908		
18	Directors Fees										
19	Professional Services			12,899	12,899		12,899	8,223	21,122		
20	Dues, Fees, Subscriptions & Promotions			4,465	4,465		4,465	806	5,271		
21	Clerical & General Office Expenses	37,105	12,754	33,459	83,318		83,318	25,028	108,346		
22	Employee Benefits & Payroll Taxes			302,824	302,824		302,824	5,114	307,938		
23	Inservice Training & Education							245	245		
24	Travel and Seminar			269	269		269	277	546		
25	Other Admin. Staff Transportation			8,574	8,574		8,574	1,949	10,523		
26	Insurance-Prop.Liab.Malpractice			36,607	36,607		36,607	1,442	38,049		
27	Other (specify):* Home Office Benefits							5,349	5,349		
28	TOTAL General Administration	92,238	12,754	574,097	679,089		679,089	(107,792)	571,297		
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,144,287	510,544	787,751	3,442,582		3,442,582	(101,065)	3,341,517		

*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.

Facility Name & ID Number Flora Rehabilitation & Health Care Center

#0046615

Report Period Beginning:

01/01/2006

Ending:

12/31/2006

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	
	D. Ownership											
30	Depreciation			182,995	182,995		182,995	(43,984)	139,011			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			197,528	197,528		197,528	27,843	225,371			32
33	Real Estate Taxes			79,974	79,974		79,974	875	80,849			33
34	Rent-Facility & Grounds							848	848			34
35	Rent-Equipment & Vehicles			18,240	18,240		18,240	444	18,684			35
36	Other (specify):*											36
37	TOTAL Ownership			478,737	478,737		478,737	(13,974)	464,763			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		58,618		58,618		58,618		58,618			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			54,203	54,203		54,203		54,203			42
43	Other (specify):* Nonallowable Cost			274,915	274,915		274,915	(274,915)				43
44	TOTAL Special Cost Centers		58,618	329,118	387,736		387,736	(274,915)	112,821			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,144,287	569,162	1,595,606	4,309,055		4,309,055	(389,954)	3,919,101			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	(2,045)	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	(51,446)	30		9
10	Interest and Other Investment Income	(2,026)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(318)	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				18
19	Entertainment				19
20	Contributions	(80)	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	(238,267)	43		24
25	Fund Raising, Advertising and Promotional	(5,143)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule <u>See Page 5A</u>	(47,201)	Var		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (346,526)		\$	30

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(43,428)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (43,428)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (389,954)		37

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

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

		1	2	3	4	
		Yes	No	Amount	Reference	
38	Medically Necessary Transport.		x	\$		38
39						39
40	Gift and Coffee Shops		x			40
41	Barber and Beauty Shops		x			41
42	Laboratory and Radiology		x			42
43	Prescription Drugs		x			43
44	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

BHF USE ONLY					
48	49	50	51	52	

SEE ACCOUNTANTS' COMPILATION REPORT

Flora Rehabilitation & Health Care Center

ID# 0046615

Report Period Beginning: 01/01/2006

Ending: 12/31/2006

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Nonallowable marketing events	\$ (5,921)	43	1
2	Labs - Part A	(12,116)	43	2
3	X-Rays - Part A	(11,025)	43	3
4	Medical Supplies	(2,267)	10	4
5	Nonallowable travel	(7,051)	24	5
6	Office Supplies	(5,238)	21	6
7	Offset meal revenue	(3,583)	2	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	(47,201)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Flora Rehabilitation & Health Care Center# 0046615

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	1,905	0	0	0	0	0	0	0	0	0	1,905	1
2	Food Purchase	(3,583)	94	0	0	0	0	0	0	0	0	0	(3,489)	2
3	Housekeeping	0	84	0	0	0	0	0	0	0	0	0	84	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	353	0	0	0	0	0	0	0	0	0	353	5
6	Maintenance	0	4,844	0	0	0	0	0	0	0	0	0	4,844	6
7	Other (specify):*	0	763	0	0	0	0	0	0	0	0	0	763	7
8	TOTAL General Services	(3,583)	8,043	0	0	0	0	0	0	0	0	0	4,460	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	(2,267)	6,887	0	0	0	0	0	0	0	0	0	4,620	10
10a	Therapy	0	632	0	0	0	0	0	0	0	0	0	632	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	2,129	0	0	0	0	0	0	0	0	0	2,129	15
16	TOTAL Health Care and Programs	(2,267)	9,648	0	0	0	0	0	0	0	0	0	7,381	16
	C. General Administration													
17	Administrative	0	(156,225)	0	0	0	0	0	0	0	0	0	(156,225)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	8,223	0	0	0	0	0	0	0	0	0	8,223	19
20	Fees, Subscriptions & Promotions	0	806	0	0	0	0	0	0	0	0	0	806	20
21	Clerical & General Office Expenses	(5,238)	0	30,266	0	0	0	0	0	0	0	0	25,028	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	245	0	0	0	0	0	0	0	0	245	23
24	Travel and Seminar	(7,051)	0	7,328	0	0	0	0	0	0	0	0	277	24
25	Other Admin. Staff Transportation	0	0	1,949	0	0	0	0	0	0	0	0	1,949	25
26	Insurance-Prop.Liab.Malpractice	0	0	1,442	0	0	0	0	0	0	0	0	1,442	26
27	Other (specify):*	0	0	5,349	0	0	0	0	0	0	0	0	5,349	27
28	TOTAL General Administration	(12,289)	(147,196)	46,579	0	(112,906)	28							
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(18,139)	(129,505)	46,579	0	(101,065)	29							

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Flora Rehabilitation & Health Care Center # 0046615 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	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	(51,446)	0	7,462	0	0	0	0	0	0	0	0	(43,984)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(2,026)	0	29,869	0	0	0	0	0	0	0	0	27,843	32
33	Real Estate Taxes	0	0	875	0	0	0	0	0	0	0	0	875	33
34	Rent-Facility & Grounds	0	0	848	0	0	0	0	0	0	0	0	848	34
35	Rent-Equipment & Vehicles	0	0	444	0	0	0	0	0	0	0	0	444	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(53,472)	0	39,498	0	(13,974)	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):*	(274,915)	0	0	0	0	0	0	0	0	0	0	(274,915)	43
44	TOTAL Special Cost Centers	(274,915)	0	0	0	0	0	0	0	0	0	0	(274,915)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(346,526)	(129,505)	86,077	0	(389,954)	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	100	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%	\$ 1,905	\$ 1,905	1
2	V	2 Food		Petersen Health Care, Inc.	100.00%	94	94	2
3	V	3 Housekeeping		Petersen Health Care, Inc.	100.00%	84	84	3
4	V	4 Laundry		Petersen Health Care, Inc.	100.00%	0		4
5	V	5 Utilities		Petersen Health Care, Inc.	100.00%	353	353	5
6	V	6 Maintenance		Petersen Health Care, Inc.	100.00%	4,844	4,844	6
7	V	7 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	763	763	7
8	V	10 Nursing and Medical Records		Petersen Health Care, Inc.	100.00%	6,887	6,887	8
9	V	10A Therapy		Petersen Health Care, Inc.	100.00%	632	632	9
10	V	15 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	2,129	2,129	10
11	V	17 Administrative	175,000	Petersen Health Care, Inc.	100.00%	18,775	(156,225)	11
12	V	19 Professional Services		Petersen Health Care, Inc.	100.00%	8,223	8,223	12
13	V	20 Due, Fees, Subs & Promos		Petersen Health Care, Inc.	100.00%	806	806	13
14	Total		\$ 175,000			\$ 45,495	\$ * (129,505)	14

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	21 Clerical & General Office	\$	Petersen Health Care, Inc.	100.00%	\$ 30,266	\$	30,266	15
16	V	23 Inservice Training & Education		Petersen Health Care, Inc.	100.00%	245		245	16
17	V	24 Travel & Seminar		Petersen Health Care, Inc.	100.00%	7,328		7,328	17
18	V	25 Other Admin. Staff Transport		Petersen Health Care, Inc.	100.00%	1,949		1,949	18
19	V	26 Insurance-Prop.Liab.Malp.		Petersen Health Care, Inc.	100.00%	1,442		1,442	19
20	V	27 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	5,349		5,349	20
21	V	30 Depreciation		Petersen Health Care, Inc.	100.00%	7,462		7,462	21
22	V	32 Interest		Petersen Health Care, Inc.	100.00%	4,145		4,145	22
23	V	32 Interest		Petersen Health Care, Inc.	100.00%	25,724		25,724	23
24	V	33 Real Estate Taxes		Petersen Health Care, Inc.	100.00%	875		875	24
25	V	34 Rent - Facility & Grounds		Petersen Health Care, Inc.	100.00%	848		848	25
26	V	35 Rent - Equipment & Vehicles		Petersen Health Care, Inc.	100.00%	444		444	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		\$			\$ 86,077	\$ *	86,077	39

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							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		\$			\$	0	\$ *

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

Facility Name & ID Number Flora Rehabilitation & Health Care Center # 0046615 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	1.17	2.35	Salary	\$ 18,774	17, 7	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	\$ 18,774		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 Flora Rehabilitation & Health Care Center

0046615

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	1,141,463	56	\$ 81,179	\$ 26,789	\$ 1,905	1
2	2	Food	Patient Days	1,141,463	56	3,989	26,789	94	2
3	3	Housekeeping	Patient Days	1,141,463	56	3,589	26,789	84	3
4	4	Laundry	Patient Days	1,141,463	56	0	26,789	0	4
5	5	Utilities	Patient Days	1,141,463	56	15,054	26,789	353	5
6	6	Maintenance	Patient Days	1,141,463	56	206,416	110,513	4,844	6
7	7	Mgmt. Allocation of Benefits	Patient Days	1,141,463	56	32,526	26,789	763	7
8	10	Nursing and Medical Records	Patient Days	1,141,463	56	293,462	289,197	6,887	8
9	10A	Therapy	Patient Days	1,141,463	56	26,945	26,789	632	9
10	15	Mgmt. Allocation of Benefits	Patient Days	1,141,463	56	90,724	26,789	2,129	10
11	17	Administrative	Patient Days	1,141,463	56	800,000	800,000	18,775	11
12	19	Professional Services	Patient Days	1,141,463	56	350,361	4,303	8,223	12
13	20	Dues, Fees, Subs & Promos	Patient Days	1,141,463	56	34,325	26,789	806	13
14	21	Clerical & General Office	Patient Days	1,141,463	56	1,289,623	954,322	30,266	14
15	23	Inservice Training & Education	Patient Days	1,141,463	56	10,426	26,789	245	15
16	24	Travel & Seminar	Patient Days	1,141,463	56	312,259	26,789	7,328	16
17	25	Other Admin. Staff Transport	Patient Days	1,141,463	56	83,062	26,789	1,949	17
18	26	Insurance-Prop.Liab.Malp.	Patient Days	1,141,463	56	61,457	26,789	1,442	18
19	27	Mgmt. Allocation of Benefits	Patient Days	1,141,463	56	227,912	26,789	5,349	19
20	30	Depreciation	Patient Days	1,141,463	56	317,964	26,789	7,462	20
21	32	Interest	Patient Days	1,141,463	56	176,614	26,789	4,145	21
21A	32	Interest	Patient Days	316,605	56	304,014	26,789	25,724	
22	33	Real Estate Taxes	Patient Days	1,141,463	56	37,282	26,789	875	22
23	34	Rent - Facility & Grounds	Patient Days	1,141,463	56	36,133	26,789	848	23
24	35	Rent - Equipment & Vehicles	Patient Days	1,141,463	56	18,933	26,789	444	24
25	TOTALS					\$ 4,814,249	\$ 2,239,302	\$ 131,572	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Flora Rehabilitation & Health Care Center# 0046615

Report Period Beginning:

01/01/2006

Ending:

12/31/2006**IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE****A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)**

1	Name of Lender	2		3	4	5	6		7	8	9	10						
		Related**					Purpose of Loan	Monthly Payment Required					Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO											Original	Balance			
	A. Directly Facility Related																	
	Long-Term																	
1	US Bank		X	Mortgage Loan	Varies	1/4/05	\$ 2,912,000	\$ 2,774,832	12/18/2011	0.0699	\$ 196,056	1						
2	Ford		X	Purchase Vehicle	\$609.00	10/27/04	33,137	19,565	10/27/2009	0.0390	899	2						
3							Amortization of Loan Costs				573	3						
4							Offset Interest Income				(2,026)	4						
5							Allocated from Home Office				29,869	5						
	Working Capital																	
6												6						
7												7						
8												8						
9	TOTAL Facility Related				\$609.00		\$ 2,945,137	\$ 2,794,397			\$ 225,371	9						
	B. Non-Facility Related*																	
10												10						
11												11						
12												12						
13												13						
14	TOTAL Non-Facility Related						\$	\$			\$	14						
15	TOTALS (line 9+line14)						\$ 2,945,137	\$ 2,794,397			\$ 225,371	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 Flora Rehabilitation & Health Care Center COUNTY Clay

FACILITY IDPH LICENSE NUMBER 0046615

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>10-23-400-014</u>	<u>Nursing Home</u>	\$ <u>59,601.86</u>	\$ <u>59,601.86</u>
2. _____	<u>Home Office Allocation</u>	\$ _____	\$ <u>875.00</u>
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>59,601.86</u>	\$ <u>60,476.86</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.

Facility Name & ID Number Flora Rehabilitation & Health Care Center

0046615

Report Period Beginning:

01/01/2006 Ending:

12/31/2006

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 24,488 B. General Construction Type: Exterior Brick Frame Steel Number of Stories One

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

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

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

N/A

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

1. Total Amount Incurred: 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	<u>Resident Care</u>	<u>278,784</u>	<u>2004</u>	<u>\$ 129,000</u>	<u>1</u>
2					<u>2</u>
3	TOTALS	278,784		\$ 129,000	3

SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)

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

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	99		2004	1973	\$ 2,214,200	\$	35	\$ 63,263	\$ 63,263	\$ 131,798	4
5											5
6											6
7	Home Office Allocation			2006	15,977			699	699	699	7
8											8
	Improvement Type**										
9	Sidewalks			2006	3,605		15	120	120	120	9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18	Building Booked					88,621			(88,621)		18
19	Building Improvement Booked					140			(140)		19
20											20
21	Home Office Allocation			2006	949			88	88	88	21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

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

See Page 12A, Line 70 for total

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)	\$	2,234,731	\$	88,761	\$	64,170	\$	(24,591)	\$	132,705	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	\$ 610,135	\$ 87,590	\$ 61,014	\$ (26,576)	10	\$ 126,582	71
72	Current Year Purchases	10,174		509	509	10	509	72
73	Fully Depreciated Assets							73
74	Home Office Allocation			6,675	6,675			74
75	TOTALS	\$ 620,309	\$ 87,590	\$ 68,198	\$ (19,392)		\$ 127,091	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	Administrative	2005 Ford	2004	\$ 33,216	\$ 6,643	\$ 6,643	\$	5	\$ 14,394	76
77										77
78										78
79										79
80	TOTALS			\$ 33,216	\$ 6,643	\$ 6,643	\$		\$ 14,394	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)	\$ 3,017,256	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 182,994	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 139,011	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (43,983)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 274,190	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

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		Allocated From Home Office			848			6
7	TOTAL				\$ 848			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 N/A.

9. Option to Buy: YES NO Terms: N/A *

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: \$ 18,684 Description: Copier 2,522; Dish machine 486; Nursing Equip. 15,232; Home Office Allocation 444

(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	<u>N/A</u>		\$	\$	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.

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?</p> <p><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>It is the policy of this facility to only hire certified nurses aides. If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. CLASSROOM PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. CLINICAL PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
--	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

\$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

- (e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
 - (f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.
- SEE ACCOUNTANTS' COMPILATION REPORT**

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

	Service	1 Schedule V Line & Column Reference	2		3	4		5	6	7	8
			Staff		Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service			Units	Cost				
1	Licensed Occupational Therapist	10A,3	1935	hrs	\$ 47,884	338	\$ 26,995	\$	2,273	\$ 74,879	1
2	Licensed Speech and Language Development Therapist	10A,3	1800	hrs	44,551	50	4,294		1,850	48,845	2
3	Licensed Recreational Therapist			hrs							3
4	Licensed Physical Therapist	10A,3	6079	hrs	150,420	379	28,965		6,458	179,385	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				43,231		43,231	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)			hrs							10
11	Academic Education			hrs							11
12	Exceptional Care Program										12
13	Other (specify): RT/Oxygen	10A,3 & 39,2				1	35	15,387	1	15,422	13
14	TOTAL				\$ 242,855	768	\$ 60,289	\$ 58,618	10,582	\$ 361,762	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 Flora Rehabilitation & Health Care Center

0046615

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	\$ 959,165	\$ 959,165	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>None</u>)	985,377	985,377	3
4	Supply Inventory (priced at _____)			4
5	Short-Term Investments			5
6	Prepaid Insurance	1,100	1,100	6
7	Other Prepaid Expenses	13,220	13,220	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): _____			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,958,862	\$ 1,958,862	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	132,605	129,000	13
14	Buildings, at Historical Cost	2,214,200	2,230,177	14
15	Leasehold Improvements, at Historical Cost		4,554	15
16	Equipment, at Historical Cost	650,025	653,525	16
17	Accumulated Depreciation (book methods)	(381,534)	(274,190)	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: <u>Loan Cost/Goodwill</u>)	21,660	21,660	22
23	Other(specify): _____			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 2,636,956	\$ 2,764,726	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 4,595,818	\$ 4,723,588	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 574,267	\$ 574,267	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	120,691	120,691	30
31	Accrued Taxes Payable (excluding real estate taxes)	3,335	3,335	31
32	Accrued Real Estate Taxes(Sch.IX-B)	60,000	60,000	32
33	Accrued Interest Payable	16,031	16,031	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Accrued Expenses</u>	25,335	25,335	36
37	<u>Due to related parties</u>	84,005	84,005	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 883,664	\$ 883,664	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	19,565	19,565	39
40	Mortgage Payable	2,774,832	2,774,832	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	_____			43
44	_____			44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 2,794,397	\$ 2,794,397	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 3,678,061	\$ 3,678,061	46
47	TOTAL EQUITY(page 18, line 24)	\$ 917,757	\$ 1,045,527	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 4,595,818	\$ 4,723,588	48

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 481,076	1
2	Restatements (describe):		2
3	Prior Year Cost Report Adjustments	(2,186)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 478,890	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	438,863	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) Rounding	4	15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 438,867	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)	\$ 917,757	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	\$ 3,341,434	1
2	Discounts and Allowances for all Levels	272,574	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,614,008	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	622,241	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 622,241	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants	238,264	10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	3,583	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	231,741	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	28,550	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 502,138	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	2,026	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 2,026	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Miscellaneous</u>	7,505	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 7,505	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 4,747,918	30

2

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	721,225	31
32	Health Care	2,042,268	32
33	General Administration	679,089	33
	B. Capital Expense		
34	Ownership	478,737	34
	C. Ancillary Expense		
35	Special Cost Centers	333,533	35
36	Provider Participation Fee	54,203	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 4,309,055	40
41	Income before Income Taxes (line 30 minus line 40)**	438,863	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 438,863	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.
This 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.

Facility Name & ID Number Flora Rehabilitation & Health Care Center

0046615

Report Period Beginning: 01/01/2006

Ending: 12/31/2006

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	2,598	2,635	\$ 54,190	\$ 20.57	1
2	Assistant Director of Nursing	2,032	2,037	43,046	21.14	2
3	Registered Nurses	15,373	15,759	283,197	17.97	3
4	Licensed Practical Nurses	16,814	17,615	303,464	17.23	4
5	CNAs & Orderlies	59,136	61,463	617,866	10.05	5
6	CNA Trainees					6
7	Licensed Therapist	9,814	9,814	242,855	24.75	7
8	Rehab/Therapy Aides					8
9	Activity Director	222	241	2,526	10.47	9
10	Activity Assistants	2,601	2,648	29,591	11.18	10
11	Social Service Workers	3,105	3,132	56,687	18.10	11
12	Dietician					12
13	Food Service Supervisor	2,080	2,080	35,422	17.03	13
14	Head Cook					14
15	Cook Helpers/Assistants	14,965	15,514	135,542	8.74	15
16	Dishwashers					16
17	Maintenance Workers	1,936	2,112	37,505	17.76	17
18	Housekeepers	14,038	14,424	102,765	7.12	18
19	Laundry	4,829	5,130	41,835	8.16	19
20	Administrator	3,020	3,028	55,133	18.21	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	3,548	3,712	37,105	10.00	23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care: Care Plan Coordinators	4,187	4,251	65,559	15.42	32
33	Other(specify) <u>Transportation</u>					33
34	TOTAL (lines 1 - 33)	160,297	165,593	\$ 2,144,287 *	\$ 12.95	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	161	\$ 9,495	1,3	35
36	Medical Director	Monthly	31,039	9,3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	1,500	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)	161	\$ 42,035		49

C. CONTRACT NURSES

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

SEE ACCOUNTANTS' COMPILATION REPORT

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
Jane Owens	Administrator	0	\$ 38,883	Workers' Compensation Insurance	\$ 59,180	IDPH License Fee	\$ 2,218	
Jami Gibbons	Administrator	0	16,250	Unemployment Compensation Insurance	45,504	Advertising: Employee Recruitment	766	
				FICA Taxes	159,605	Health Care Worker Background Check (Indicate # of checks performed <u>87</u>)	1,040	
				Employee Health Insurance	33,296	Patient Background Checks		
				Employee Meals	5,114	Miscellaneous Dues & Subscriptions	441	
				Illinois Municipal Retirement Fund (IMRF)*				
				Employee Retirement	1,339			
				Employee Relations	3,900			
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 55,133			Allocated From Home Office	806	
B. Administrative - Other						Less: Public Relations Expense	()	
Description			Amount			Non-allowable advertising	()	
Management Fee Expense (eliminated in Col. 7)			\$ 175,000			Yellow page advertising	()	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 175,000	TOTAL (agree to Schedule V, line 22, col.8)	\$ 307,938	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 5,271	
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount
Altschuler, Melvoin & Glasser, LLP	Accounting		\$ 5,850	N/A			Out-of-State Travel	\$
Lindon Engineering Services	Accounting		3,578					
IVANS	Computer Services		141				In-State Travel	
Wabash Independent Networks	Computer Services		689					
LTC Solutions	Computer Services		2,640				Seminar Expense	250
							Meals	19
							Allocated From Home Office	277
							Entertainment Expense	()
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 12,899	TOTAL		\$	TOTAL (agree to Sch. V, line 24, col. 8)	\$ 546

* Attach copy of IMRF notifications
SEE ACCOUNTANTS' COMPILATION REPORT

**See instructions.

Petersen Health Care, Inc. (Flora Rehab)
Provider Number - 0046615
FYE: 12/31/2006

Schedule 21A

XIX. SUPPORT SCHEDULE
C. Professional Services

Total (agree to Schedule V, line 19, column 3) 12,899

Allocated from Home Office
Other Professional Fees
Legal

8,114
109
8,223

Total (agree to Schedule V, line 19, column 8) 21,122

See Accountants' Compilation Report

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

(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009	FY2010	FY2011
1			\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6								N/A					
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

