

Facility Name & ID Number North Aurora Care Center

0047514 Report Period Beginning: 01/01/06 Ending: 12/31/06

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		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3	129	Intermediate (ICF)	129	47,085	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	129	TOTALS	129	47,085	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	
8	SNF				8
9	SNF/PED				9
10	ICF	1,721	36,349		38,070
11	ICF/DD				11
12	SC				12
13	DD 16 OR LESS				13
14	TOTALS	1,721	36,349		38,070

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 80.85%

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 10/01/05

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

YES Date 10/01/05 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

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 North Aurora Care Center # 0047514 Report Period Beginning: 01/01/06 Ending: 12/31/06

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	154,155	12,464	5,722	172,341		172,341	3,782	176,123		1
2	Food Purchase		131,468		131,468		131,468	(4,278)	127,190		2
3	Housekeeping	93,214	14,752		107,966		107,966	122	108,088		3
4	Laundry	42,736	9,375		52,111		52,111		52,111		4
5	Heat and Other Utilities			75,181	75,181		75,181	502	75,683		5
6	Maintenance	26,011	29,283	12,381	67,675		67,675	9,378	77,053		6
7	Other (specify):* Home Office Benefits							2,356	2,356		7
8	TOTAL General Services	316,116	197,342	93,284	606,742		606,742	11,862	618,604		8
	B. Health Care and Programs										
9	Medical Director										9
10	Nursing and Medical Records	1,219,913	35,624	9,485	1,265,022		1,265,022	11,684	1,276,706		10
10a	Therapy			1,072	1,072		1,072	899	1,971		10a
11	Activities	66,795	2,426	3,049	72,270		72,270		72,270		11
12	Social Services	113,795	759		114,554		114,554		114,554		12
13	CNA Training										13
14	Program Transportation			25	25		25		25		14
15	Other (specify):* Home Office Benefits							3,676	3,676		15
16	TOTAL Health Care and Programs	1,400,503	38,809	13,631	1,452,943		1,452,943	16,259	1,469,202		16
	C. General Administration										
17	Administrative	87,083		80,500	167,583		167,583	(51,558)	116,025		17
18	Directors Fees										18
19	Professional Services			2,079	2,079		2,079	15,733	17,812		19
20	Dues, Fees, Subscriptions & Promotions			2,179	2,179		2,179	1,865	4,044		20
21	Clerical & General Office Expenses	25,138	5,385	12,094	42,617		42,617	53,605	96,222		21
22	Employee Benefits & Payroll Taxes			304,957	304,957		304,957	2,936	307,893		22
23	Inservice Training & Education							348	348		23
24	Travel and Seminar							1,004	1,004		24
25	Other Admin. Staff Transportation			7,336	7,336		7,336	4,106	11,442		25
26	Insurance-Prop.Liab.Malpractice			34,108	34,108		34,108	2,147	36,255		26
27	Other (specify):* Home Office Benefits							10,473	10,473		27
28	TOTAL General Administration	112,221	5,385	443,253	560,859		560,859	40,659	601,518		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,828,840	241,536	550,168	2,620,544		2,620,544	68,780	2,689,324		29

SEE ACCOUNTANTS' COMPILATION REPORT

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

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

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

Facility Name & ID Number North Aurora Care Center

#0047514

Report Period Beginning:

01/01/06

Ending:

12/31/06

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			96,551	96,551		96,551	12,601	109,152			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			157,074	157,074		157,074	28,041	185,115			32
33	Real Estate Taxes			38,200	38,200		38,200	3,761	41,961			33
34	Rent-Facility & Grounds							1,712	1,712			34
35	Rent-Equipment & Vehicles			6,926	6,926		6,926	1,119	8,045			35
36	Other (specify):*											36
37	TOTAL Ownership			298,751	298,751		298,751	47,234	345,985			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		2,035	3,320	5,355		5,355		5,355			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			70,628	70,628		70,628		70,628			42
43	Other (specify):* Nonallowable Cost			7,525	7,525		7,525	(7,525)				43
44	TOTAL Special Cost Centers		2,035	81,473	83,508		83,508	(7,525)	75,983			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,828,840	243,571	930,392	3,002,803		3,002,803	108,489	3,111,292			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

Facility Name & ID Number North Aurora Care Center

0047514

Report Period Beginning:

01/01/06

Ending:

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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	(840)	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	(78)	30		9
10	Interest and Other Investment Income	(11,057)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(150)	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	(247)	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				24
25	Fund Raising, Advertising and Promotional	(2,463)	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 Pg 5A	(16,913)	Var.		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (31,748)		\$	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)	140,237		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 140,237		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ 108,489		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

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%	\$ 2,707	\$ 2,707	1
2	V	2 Food		Petersen Health Care, Inc.	100.00%	133	133	2
3	V	3 Housekeeping		Petersen Health Care, Inc.	100.00%	120	120	3
4								4
5	V	5 Utilities		Petersen Health Care, Inc.	100.00%	502	502	5
6	V	6 Maintenance		Petersen Health Care, Inc.	100.00%	6,884	6,884	6
7	V	7 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	1,085	1,085	7
8	V	10 Nursing and Medical Records		Petersen Health Care, Inc.	100.00%	9,788	9,788	8
9	V	10A Therapy		Petersen Health Care, Inc.	100.00%	899	899	9
10	V	15 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	3,026	3,026	10
11	V	17 Administrative	80,500	Petersen Health Care, Inc.	100.00%	26,682	(53,818)	11
12	V	19 Professional Services		Petersen Health Care, Inc.	100.00%	11,685	11,685	12
13	V	20 Due, Fees, Subs & Promos		Petersen Health Care, Inc.	100.00%	1,145	1,145	13
14	Total		\$ 80,500			\$ 64,656	\$ * (15,844)	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%	\$ 43,011	\$	43,011	15
16	V	23 Inservice Training & Education		Petersen Health Care, Inc.	100.00%	348		348	16
17	V	24 Travel and Seminar		Petersen Health Care, Inc.	100.00%	10,414		10,414	17
18	V	25 Other Admin. Staff Transport		Petersen Health Care, Inc.	100.00%	2,770		2,770	18
19	V	26 Insurance-Prop.Liab.Malpractice		Petersen Health Care, Inc.	100.00%	2,050		2,050	19
20	V	27 Mgmt Allocation of Benefits		Petersen Health Care, Inc.	100.00%	7,601		7,601	20
21	V	30 Depreciation		Petersen Health Care, Inc.	100.00%	10,605		10,605	21
22	V	32 Interest		Petersen Health Care, Inc.	100.00%	5,890		5,890	22
23	V	33 Real Estate Taxes		Petersen Health Care, Inc.	100.00%	1,243		1,243	23
24	V	34 Rent - Facility & Grounds		Petersen Health Care, Inc.	100.00%	1,205		1,205	24
25	V	35 Rent - Equipment & Vehicles		Petersen Health Care, Inc.	100.00%	631		631	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		\$			\$ 85,768	\$ *	85,768	39

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	1 Dietary	\$	Petersen Health Care, Inc.	100.00%	\$ 1,075	\$	1,075	15
16	V	2 Food		Petersen Health Care, Inc.	100.00%	8		8	16
17	V	3 Housekeeping		Petersen Health Care, Inc.	100.00%	2		2	17
18									18
19									19
20	V	6 Maintenance		Petersen Health Care, Inc.	100.00%	2,494		2,494	20
21	V	7 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	1,271		1,271	21
22	V	10 Nursing and Medical Records		Petersen Health Care, Inc.	100.00%	1,896		1,896	22
23									23
24	V	15 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	650		650	24
25	V	17 Administrative		Petersen Health Care, Inc.	100.00%	2,260		2,260	25
26	V	19 Professional Services		Petersen Health Care, Inc.	100.00%	4,893		4,893	26
27	V	20 Due, Fees, Subs & Promos		Petersen Health Care, Inc.	100.00%	720		720	27
28	V	21 Clerical & General Office		Petersen Health Care, Inc.	100.00%	10,940		10,940	28
29									29
30	V	24 Travel and Seminar		Petersen Health Care, Inc.	100.00%	1,004		1,004	30
31	V	25 Other Admin. Staff Transport		Petersen Health Care, Inc.	100.00%	1,336		1,336	31
32	V	26 Insurance-Prop.Liab.Malpractice		Petersen Health Care, Inc.	100.00%	97		97	32
33	V	27 Mgmt Allocation of Benefits		Petersen Health Care, Inc.	100.00%	2,872		2,872	33
34	V	30 Depreciation		Petersen Health Care, Inc.	100.00%	2,074		2,074	34
35	V	32 Interest		Petersen Health Care, Inc.	100.00%	33,208		33,208	35
36	V	33 Real Estate Taxes		Petersen Health Care, Inc.	100.00%	2,518		2,518	36
37	V	34 Rent - Facility & Grounds		Petersen Health Care, Inc.	100.00%	507		507	37
38	V	35 Rent - Equipment & Vehicles		Petersen Health Care, Inc.	100.00%	488		488	38
39	Total		\$			\$ 70,313	\$ *	70,313	39

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

Facility Name & ID Number North Aurora Care Center # 0047514 Report Period Beginning: 01/01/06 Ending: 12/31/06

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	1.67	3.34	Salary	\$ 26,680	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	\$ 26,680		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 North Aurora Care Center

0047514

Report Period Beginning:

01/01/06

Ending: 12/31/06

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	<u>1</u>	<u>Dietary</u>	<u>Patient Days</u>	<u>1,141,463</u>	<u>56</u>	<u>\$ 81,179</u>	<u>\$ 80,967</u>	<u>38,070</u>	<u>\$ 2,707</u>	<u>1</u>
2	<u>2</u>	<u>Food</u>	<u>Patient Days</u>	<u>1,141,463</u>	<u>56</u>	<u>3,989</u>	<u>0</u>	<u>38,070</u>	<u>133</u>	<u>2</u>
3	<u>3</u>	<u>Housekeeping</u>	<u>Patient Days</u>	<u>1,141,463</u>	<u>56</u>	<u>3,589</u>	<u>0</u>	<u>38,070</u>	<u>120</u>	<u>3</u>
4										<u>4</u>
5	<u>5</u>	<u>Utilities</u>	<u>Patient Days</u>	<u>1,141,463</u>	<u>56</u>	<u>15,054</u>	<u>0</u>	<u>38,070</u>	<u>502</u>	<u>5</u>
6	<u>6</u>	<u>Maintenance</u>	<u>Patient Days</u>	<u>1,141,463</u>	<u>56</u>	<u>206,416</u>	<u>110,513</u>	<u>38,070</u>	<u>6,884</u>	<u>6</u>
7	<u>7</u>	<u>Mgmt. Allocation of Benefits</u>	<u>Patient Days</u>	<u>1,141,463</u>	<u>56</u>	<u>32,526</u>	<u>0</u>	<u>38,070</u>	<u>1,085</u>	<u>7</u>
8	<u>10</u>	<u>Nursing and Medical Records</u>	<u>Patient Days</u>	<u>1,141,463</u>	<u>56</u>	<u>293,462</u>	<u>289,197</u>	<u>38,070</u>	<u>9,788</u>	<u>8</u>
9	<u>10A</u>	<u>Therapy</u>	<u>Patient Days</u>	<u>1,141,463</u>	<u>56</u>	<u>26,945</u>	<u>0</u>	<u>38,070</u>	<u>899</u>	<u>9</u>
10	<u>15</u>	<u>Mgmt. Allocation of Benefits</u>	<u>Patient Days</u>	<u>1,141,463</u>	<u>56</u>	<u>90,724</u>	<u>0</u>	<u>38,070</u>	<u>3,026</u>	<u>10</u>
11	<u>17</u>	<u>Administrative</u>	<u>Patient Days</u>	<u>1,141,463</u>	<u>56</u>	<u>800,000</u>	<u>800,000</u>	<u>38,070</u>	<u>26,682</u>	<u>11</u>
12	<u>19</u>	<u>Professional Services</u>	<u>Patient Days</u>	<u>1,141,463</u>	<u>56</u>	<u>350,361</u>	<u>4,303</u>	<u>38,070</u>	<u>11,685</u>	<u>12</u>
13	<u>20</u>	<u>Due, Fees, Subs & Promos</u>	<u>Patient Days</u>	<u>1,141,463</u>	<u>56</u>	<u>34,325</u>	<u>0</u>	<u>38,070</u>	<u>1,145</u>	<u>13</u>
14	<u>21</u>	<u>Clerical & General Office</u>	<u>Patient Days</u>	<u>1,141,463</u>	<u>56</u>	<u>1,289,623</u>	<u>954,322</u>	<u>38,070</u>	<u>43,011</u>	<u>14</u>
15	<u>23</u>	<u>Inservice Training & Education</u>	<u>Patient Days</u>	<u>1,141,463</u>	<u>56</u>	<u>10,426</u>	<u>0</u>	<u>38,070</u>	<u>348</u>	<u>15</u>
16	<u>24</u>	<u>Travel and Seminar</u>	<u>Patient Days</u>	<u>1,141,463</u>	<u>56</u>	<u>312,259</u>	<u>0</u>	<u>38,070</u>	<u>10,414</u>	<u>16</u>
17	<u>25</u>	<u>Other Admin. Staff Transport</u>	<u>Patient Days</u>	<u>1,141,463</u>	<u>56</u>	<u>83,062</u>	<u>0</u>	<u>38,070</u>	<u>2,770</u>	<u>17</u>
18	<u>26</u>	<u>Insurance-Prop.Liab.Malpractice</u>	<u>Patient Days</u>	<u>1,141,463</u>	<u>56</u>	<u>61,457</u>	<u>0</u>	<u>38,070</u>	<u>2,050</u>	<u>18</u>
19	<u>27</u>	<u>Mgmt Allocation of Benefits</u>	<u>Patient Days</u>	<u>1,141,463</u>	<u>56</u>	<u>227,912</u>	<u>0</u>	<u>38,070</u>	<u>7,601</u>	<u>19</u>
20	<u>30</u>	<u>Depreciation</u>	<u>Patient Days</u>	<u>1,141,463</u>	<u>56</u>	<u>317,964</u>	<u>0</u>	<u>38,070</u>	<u>10,605</u>	<u>20</u>
21	<u>32</u>	<u>Interest</u>	<u>Patient Days</u>	<u>1,141,463</u>	<u>56</u>	<u>176,614</u>	<u>0</u>	<u>38,070</u>	<u>5,890</u>	<u>21</u>
22	<u>33</u>	<u>Real Estate Taxes</u>	<u>Patient Days</u>	<u>1,141,463</u>	<u>56</u>	<u>37,282</u>	<u>0</u>	<u>38,070</u>	<u>1,243</u>	<u>22</u>
23	<u>34</u>	<u>Rent - Facility & Grounds</u>	<u>Patient Days</u>	<u>1,141,463</u>	<u>56</u>	<u>36,133</u>	<u>0</u>	<u>38,070</u>	<u>1,205</u>	<u>23</u>
24	<u>35</u>	<u>Rent - Equipment & Vehicles</u>	<u>Patient Days</u>	<u>1,141,463</u>	<u>56</u>	<u>18,933</u>	<u>0</u>	<u>38,070</u>	<u>631</u>	<u>24</u>
25	TOTALS					\$ 4,510,235	\$ 2,239,302		\$ 150,424	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number North Aurora Care Center

0047514

Report Period Beginning:

01/01/06

Ending: 12/31/06

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	<u>1</u>	<u>Dietary</u>	<u>Patient Days</u>	<u>46</u>	<u>\$ 12,081</u>	<u>\$ 11,958</u>	<u>38,070</u>	<u>\$ 1,075</u>	<u>1</u>
2	<u>2</u>	<u>Food</u>	<u>Patient Days</u>	<u>46</u>	<u>93</u>	<u>0</u>	<u>38,070</u>	<u>8</u>	<u>2</u>
3	<u>3</u>	<u>Housekeeping</u>	<u>Patient Days</u>	<u>46</u>	<u>28</u>	<u>0</u>	<u>38,070</u>	<u>2</u>	<u>3</u>
4									<u>4</u>
5									<u>5</u>
6	<u>6</u>	<u>Maintenance</u>	<u>Patient Days</u>	<u>46</u>	<u>28,012</u>	<u>28,012</u>	<u>38,070</u>	<u>2,494</u>	<u>6</u>
7	<u>7</u>	<u>Mgmt. Allocation of Benefits</u>	<u>Patient Days</u>	<u>46</u>	<u>14,282</u>	<u>0</u>	<u>38,070</u>	<u>1,271</u>	<u>7</u>
8	<u>10</u>	<u>Nursing and Medical Records</u>	<u>Patient Days</u>	<u>46</u>	<u>21,299</u>	<u>20,434</u>	<u>38,070</u>	<u>1,896</u>	<u>8</u>
9									<u>9</u>
10	<u>15</u>	<u>Mgmt. Allocation of Benefits</u>	<u>Patient Days</u>	<u>46</u>	<u>7,301</u>	<u>0</u>	<u>38,070</u>	<u>650</u>	<u>10</u>
11	<u>17</u>	<u>Administrative</u>	<u>Patient Days</u>	<u>46</u>	<u>25,391</u>	<u>25,391</u>	<u>38,070</u>	<u>2,260</u>	<u>11</u>
12	<u>19</u>	<u>Professional Services</u>	<u>Patient Days</u>	<u>46</u>	<u>54,971</u>	<u>0</u>	<u>38,070</u>	<u>4,893</u>	<u>12</u>
13	<u>20</u>	<u>Due, Fees, Subs & Promos</u>	<u>Patient Days</u>	<u>46</u>	<u>8,088</u>	<u>0</u>	<u>38,070</u>	<u>720</u>	<u>13</u>
14	<u>21</u>	<u>Clerical & General Office</u>	<u>Patient Days</u>	<u>46</u>	<u>122,893</u>	<u>64,907</u>	<u>38,070</u>	<u>10,940</u>	<u>14</u>
15									<u>15</u>
16	<u>24</u>	<u>Travel and Seminar</u>	<u>Patient Days</u>	<u>46</u>	<u>11,280</u>	<u>0</u>	<u>38,070</u>	<u>1,004</u>	<u>16</u>
17	<u>25</u>	<u>Other Admin. Staff Transport</u>	<u>Patient Days</u>	<u>46</u>	<u>15,003</u>	<u>0</u>	<u>38,070</u>	<u>1,336</u>	<u>17</u>
18	<u>26</u>	<u>Insurance-Prop.Liab.Malpractice</u>	<u>Patient Days</u>	<u>46</u>	<u>1,087</u>	<u>0</u>	<u>38,070</u>	<u>97</u>	<u>18</u>
19	<u>27</u>	<u>Mgmt Allocation of Benefits</u>	<u>Patient Days</u>	<u>46</u>	<u>32,265</u>	<u>0</u>	<u>38,070</u>	<u>2,872</u>	<u>19</u>
20	<u>30</u>	<u>Depreciation</u>	<u>Patient Days</u>	<u>46</u>	<u>23,301</u>	<u>0</u>	<u>38,070</u>	<u>2,074</u>	<u>20</u>
21	<u>32</u>	<u>Interest</u>	<u>Patient Days</u>	<u>46</u>	<u>373,049</u>	<u>0</u>	<u>38,070</u>	<u>33,208</u>	<u>21</u>
22	<u>33</u>	<u>Real Estate Taxes</u>	<u>Patient Days</u>	<u>46</u>	<u>28,282</u>	<u>0</u>	<u>38,070</u>	<u>2,518</u>	<u>22</u>
23	<u>34</u>	<u>Rent - Facility & Grounds</u>	<u>Patient Days</u>	<u>46</u>	<u>5,700</u>	<u>0</u>	<u>38,070</u>	<u>507</u>	<u>23</u>
24	<u>35</u>	<u>Rent - Equipment & Vehicles</u>	<u>Patient Days</u>	<u>46</u>	<u>5,479</u>	<u>0</u>	<u>38,070</u>	<u>488</u>	<u>24</u>
25	TOTALS				\$ 789,885	\$ 150,702		\$ 70,313	25

SEE ACCOUNTANTS' COMPILATION REPORT

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North Aurora Care Center

0047514

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12/31/06

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	LaSalle Bank		X	Mortgage	Varies	09/30/05	\$ 1,370,000	\$ 1,350,002	09/20/10	Varies	\$ 116,484	1						
2	Ziegler Healthcare		X	Mortgage	Varies	09/30/05	260,000	259,524	09/20/10	0.1000	40,591	2						
3												3						
4							Allocation from Home Office				39,098	4						
5							Offset Interest Income				(11,057)	5						
Working Capital																		
6												6						
7												7						
8												8						
9	TOTAL Facility Related						\$ 1,630,000	\$ 1,609,526			\$ 185,115	9						
B. Non-Facility Related*																		
10												10						
11												11						
12												12						
13												13						
14	TOTAL Non-Facility Related						\$	\$			\$	14						
15	TOTALS (line 9+line14)						\$ 1,630,000	\$ 1,609,526			\$ 185,115	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.)

Facility Name & ID Number North Aurora Care Center

0047514

Report Period Beginning:

01/01/06

Ending:

12/31/06

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 27,812 B. General Construction Type: Exterior Masonry Frame Brick Number of Stories 1

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

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

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

N/A

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

1. Total Amount Incurred: 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:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	<u>Facility</u>	<u>27,812</u>	<u>2005</u>	<u>\$ 72,000</u>	<u>1</u>
2					<u>2</u>
3	TOTALS	<u>27,812</u>		<u>\$ 72,000</u>	<u>3</u>

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	129	2005	1972	\$ 1,298,500	\$	25	\$ 51,940	\$ 51,940	\$ 77,910	4
5		2005								5
6										6
7	06 Home Office									7
8	Allocation	2006		22,705			993	993	993	8
Improvement Type**										
9	Original Land Improvements		2005	15,000		15	1,000	1,000	1,500	9
10	Sidewalks		2006	23,280		15	776	776	776	10
11	New Wall In		2006	2,425		25	49	49	49	11
12	Water Line Replacement		2006	3,775		25	76	76	76	12
13	Water Pump Replacement		2006	3,200		15	107	107	107	13
14										14
15										15
16	Land Improvement Booked				1,388			(1,388)		16
17	Building Booked				51,981			(51,981)		17
18	Building Improvement Booked				53			(53)		18
19										19
20	2006 Home Office allocation - Land & Land Improvements		2006	1,312			122	122	122	20
21	2006 Home Office allocation - Buildings Improvements		2006	37			3	3	3	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)	\$	\$		\$	\$	\$	70	
			1,370,234		53,421		55,066	1,645	81,536

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number North Aurora Care Center

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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	\$ 269,353	\$ 43,130	\$ 40,960	\$ (2,170)	3-10	\$ 61,443	71
72	Current Year Purchases	17,203		1,565	1,565	5-10	2,093	72
73	Fully Depreciated Assets							73
74	Home Office Allocation			11,561	11,561			74
75	TOTALS	\$ 286,556	\$ 43,130	\$ 54,086	\$ 10,956		\$ 63,536	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	N/A			\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 1,728,790	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 96,551	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 109,152	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 12,601	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 145,072	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	N/A	\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

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

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

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

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		Home Office Allocation			1,712			6
7	TOTAL				\$ 1,712			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: \$ 8,045 Description: Copier-3,225; Dishwasher-743; HO Allocation \$1,119; Nursing Equip. \$2,868; Cleaning \$90

(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.

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)	hrs			1	\$ 105					1	\$	105		1
2	Licensed Speech and Language Development Therapist		hrs													2
3	Licensed Recreational Therapist		hrs													3
4	Licensed Physical Therapist	10A(3)	hrs			13	967					13		967		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							2,035				2,035		9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs													10
11	Academic Education		hrs													11
12	Exceptional Care Program	39(3)				42	3,320					42		3,320		12
13	Other (specify):															13
14	TOTAL				\$	56	\$ 4,392	\$	2,035	\$	56	\$	6,427			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 North Aurora Care Center

0047514

Report Period Beginning: 01/01/06

Ending:

12/31/06

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/06

(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	\$ 323,764	\$ 323,764	1
2	Cash-Patient Deposits	1,166	1,166	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>none</u>)	632,810	632,810	3
4	Supply Inventory (priced at _____)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	2,154	2,154	7
8	Accounts Receivable (owners or related parties)	8,785	8,785	8
9	Other(specify): _____			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 968,679	\$ 968,679	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost	1,418,182	1,442,234	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	286,556	286,556	16
17	Accumulated Depreciation (book methods)	(116,805)	(145,072)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify): _____			22
23	Other(specify): _____			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,587,933	\$ 1,583,718	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,556,612	\$ 2,552,397	25

		1	2	
		Operating	After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 152,302	\$ 152,302	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	34,444	34,444	30
31	Accrued Taxes Payable (excluding real estate taxes)	5,233	5,233	31
32	Accrued Real Estate Taxes(Sch.IX-B)	38,200	38,200	32
33	Accrued Interest Payable	16,758	16,758	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	<u>Accrued Expenses</u>	20,517	20,517	36
37	_____			37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 267,454	\$ 267,454	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable			39
40	Mortgage Payable	259,524	259,524	40
41	Bonds Payable	1,350,002	1,350,002	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)	\$ 1,609,526	\$ 1,609,526	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,876,980	\$ 1,876,980	46
47	TOTAL EQUITY(page 18, line 24)	\$ 679,632	\$ 675,417	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,556,612	\$ 2,552,397	48

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 186,629	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 186,629	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	493,003	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)	\$ 493,003	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)	\$ 679,632	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	\$ 3,483,559	1
2	Discounts and Allowances for all Levels	(640)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,482,919	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	10	14
15	Telephone, Television and Radio		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)	\$ 10	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	11,058	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 11,058	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Vending	1,473	28
28a	Miscellaneous	346	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 1,819	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 3,495,806	30

2

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	606,742	31
32	Health Care	1,452,943	32
33	General Administration	560,859	33
	B. Capital Expense		
34	Ownership	298,751	34
	C. Ancillary Expense		
35	Special Cost Centers	12,880	35
36	Provider Participation Fee	70,628	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 3,002,803	40
41	Income before Income Taxes (line 30 minus line 40)**	493,003	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 493,003	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 North Aurora Care Center

0047514

Report Period Beginning:

01/01/06

Ending:

12/31/06

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	2,080	2,080	\$ 74,170	\$ 35.66	1
2	Assistant Director of Nursing					2
3	Registered Nurses	10,061	10,189	277,179	27.20	3
4	Licensed Practical Nurses	10,140	10,340	256,099	24.77	4
5	CNAs & Orderlies	46,065	46,843	612,465	13.07	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,987	2,043	29,814	14.59	9
10	Activity Assistants	3,786	3,853	36,981	9.60	10
11	Social Service Workers	7,958	8,003	113,795	14.22	11
12	Dietician					12
13	Food Service Supervisor	2,080	2,080	34,923	16.79	13
14	Head Cook					14
15	Cook Helpers/Assistants	13,347	13,448	119,232	8.87	15
16	Dishwashers					16
17	Maintenance Workers	2,049	2,089	26,011	12.45	17
18	Housekeepers	11,264	11,264	93,214	8.28	18
19	Laundry	5,389	5,471	42,736	7.81	19
20	Administrator	2,000	2,000	87,083	43.54	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	2,064	2,088	25,138	12.04	23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	120,270	121,791	\$ 1,828,840 *	\$ 15.02	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	132	\$ 5,722	1,3	35
36	Medical Director				36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	2,285	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	Psychology Consultant	Monthly	7,200	10,3	47
48					48
49	TOTAL (lines 35 - 48)	132	\$ 15,207		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	
<u>Quinn Corcoran</u>	<u>Administrator</u>	<u>0</u>	\$ <u>87,083</u>	<u>Workers' Compensation Insurance</u>	\$ <u>51,600</u>	<u>IDPH License Fee</u>	\$ <u>1,579</u>	
				<u>Unemployment Compensation Insurance</u>	<u>76,296</u>	<u>Advertising: Employee Recruitment</u>		
				<u>FICA Taxes</u>	<u>134,704</u>	<u>Health Care Worker Background Check</u>		
				<u>Employee Health Insurance</u>	<u>35,131</u>	(Indicate # of checks performed <u>50</u>)	<u>600</u>	
				<u>Employee Meals</u>	<u>2,936</u>	<u>Patient Background Checks</u>	<u>0</u>	
				<u>Illinois Municipal Retirement Fund (IMRF)*</u>				
				<u>401K Matching</u>	<u>64</u>	<u>Allocated from Home Office</u>	<u>1,865</u>	
				<u>Employee Relations</u>	<u>7,162</u>			
TOTAL (agree to Schedule V, line 17, col. 1)			\$ <u>87,083</u>	TOTAL (agree to Schedule V, line 22, col.8)			\$ <u>307,893</u>	
(List each licensed administrator separately.)				(agree to Sch. V, line 20, col. 8)			\$ <u>4,044</u>	
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Description			Amount	Description	Line #	Amount	Description	Amount
<u>Management Fee Expense (Eliminated from column 7)</u>			\$ <u>80,500</u>	<u>N/A</u>			<u>Out-of-State Travel</u>	\$
							<u>In-State Travel</u>	
TOTAL (agree to Schedule V, line 17, col. 3)			\$ <u>80,500</u>	TOTAL				
(Attach a copy of any management service agreement)							<u>Seminar Expense</u>	
C. Professional Services				G. Schedule of Travel and Seminar**			G. Schedule of Travel and Seminar**	
Vendor/Payee	Type			Description	Line #	Amount	Description	Amount
<u>LTC Solutions</u>	<u>Computer Service</u>	\$ <u>530</u>					<u>Allocated from Home Office</u>	<u>1,004</u>
<u>SBC</u>	<u>Computer Service</u>	<u>196</u>						
<u>AT&T</u>	<u>Computer Service</u>	<u>33</u>					<u>Entertainment Expense</u>	
<u>LTC Solutions</u>	<u>Computer Service</u>	<u>1,320</u>					(agree to Sch. V, line 24, col. 8)	
TOTAL (agree to Schedule V, line 19, column 3)			\$ <u>2,079</u>	TOTAL				
(If total legal fees exceed \$5,000, attach copy of invoices.)							TOTAL	\$ <u>1,004</u>

* Attach copy of IMRF notifications
SEE ACCOUNTANTS' COMPILATION REPORT

**See instructions.

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								
													Amount of Expense Amortized Per Year							
													Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	FY2003	FY2004	FY2005	FY2006
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 North Aurora Care Center# 0047514Report Period Beginning: 01/01/06Ending: 12/31/06**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? No
If YES, give association name and amount. N/A
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 5 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 5,455 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 70,628
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.

SEE ACCOUNTANTS' COMPILATION REPORT

- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 2,936 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 10
- (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? N/A
- 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