



Facility Name & ID Number Batavia Rehabilitation & Health Care Center

# 0047399 Report Period Beginning: 01/01/2007 Ending: 12/31/2007

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	63	Intermediate (ICF)	63	22,995	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	63	TOTALS	63	22,995	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF					8
9	SNF/PED					9
10	ICF	14,808	2,724		17,532	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	14,808	2,724		17,532	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 76.24%

D. How many bed-hold days during this year were paid by the Department?

None (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)

None

F. Does the facility maintain a daily midnight census?

Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?

YES

NO

Non-allowable costs have been eliminated in Schedule V, Column 7

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES

NO

I. On what date did you start providing long term care at this location?

Date started 10/01/2005

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

YES

Date 10/01/2005

NO

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

YES

NO

If YES, enter number of beds certified 0 and days of care provided 0

Medicare Intermediary N/A

IV. ACCOUNTING BASIS

ACCRUAL

MODIFIED

CASH\*

CASH\*

Is your fiscal year identical to your tax year?

YES

NO

Tax Year: 12/31/2007 Fiscal Year: 12/31/2007

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

Facility Name & ID Number Batavia Rehabilitation & Health Care Center # 0047399 Report Period Beginning: 01/01/2007 Ending: 12/31/2007

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7**	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>A. General Services</b>										
1	Dietary	115,288	9,428	2,940	127,656		127,656	3,530	131,186		1
2	Food Purchase		92,337		92,337		92,337	(1,626)	90,711		2
3	Housekeeping	80,986	10,349		91,335		91,335	17	91,352		3
4	Laundry	20,055	6,813		26,868		26,868	1	26,869		4
5	Heat and Other Utilities			49,995	49,995		49,995	251	50,246		5
6	Maintenance	26,027	5,423	21,474	52,924		52,924	2,058	54,982		6
7	Other (specify):* Home Off. Ben. All.							2,390	2,390		7
8	<b>TOTAL General Services</b>	242,356	124,350	74,409	441,115		441,115	6,621	447,736		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			6,200	6,200		6,200		6,200		9
10	Nursing and Medical Records	751,008	51,027	65,974	868,009		868,009	6,303	874,312		10
10a	Therapy		26		26		26		26		10a
11	Activities	27,782	620	242	28,644		28,644		28,644		11
12	Social Services	32,233			32,233		32,233		32,233		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* Home Off. Ben. All.							2,879	2,879		15
16	<b>TOTAL Health Care and Programs</b>	811,023	51,673	72,416	935,112		935,112	9,182	944,294		16
	<b>C. General Administration</b>										
17	Administrative	71,497		33,000	104,497		104,497	(13,652)	90,845		17
18	Directors Fees										18
19	Professional Services			12,268	12,268		12,268	5,399	17,667		19
20	Dues, Fees, Subscriptions & Promotions			9,454	9,454		9,454	352	9,806		20
21	Clerical & General Office Expenses	33,690	4,087	7,241	45,018		45,018	27,039	72,057		21
22	Employee Benefits & Payroll Taxes			164,185	164,185		164,185		164,185		22
23	Inservice Training & Education			75	75		75	286	361		23
24	Travel and Seminar			745	745		745	455	1,200		24
25	Other Admin. Staff Transportation			2,922	2,922		2,922	2,966	5,888		25
26	Insurance-Prop.Liab.Malpractice			10,771	10,771		10,771	671	11,442		26
27	Other (specify):* Home Off. Ben. All.							14,139	14,139		27
28	<b>TOTAL General Administration</b>	105,187	4,087	240,661	349,935		349,935	37,655	387,590		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	1,158,566	180,110	387,486	1,726,162		1,726,162	53,458	1,779,620		29

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

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

Facility Name &amp; ID Number

Batavia Rehabilitation &amp; Health Care Center

#0047399

Report Period Beginning:

01/01/2007

Ending:

12/31/2007

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7**	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>D. Ownership</b>											
30	Depreciation			7,987	7,987		7,987	3,813	11,800			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			20,491	20,491		20,491	39,257	59,748			32
33	Real Estate Taxes			42,665	42,665		42,665	574	43,239			33
34	Rent-Facility & Grounds							35	35			34
35	Rent-Equipment & Vehicles			5,986	5,986		5,986	462	6,448			35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			77,129	77,129		77,129	44,141	121,270			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		41		41		41		41			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			34,493	34,493		34,493		34,493			42
43	Other (specify):* Non-allowable Cost		481	1,215	1,696		1,696	(1,696)				43
44	<b>TOTAL Special Cost Centers</b>		522	35,708	36,230		36,230	(1,696)	34,534			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	1,158,566	180,632	500,323	1,839,521		1,839,521	95,903	1,935,424			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.

**VI. ADJUSTMENT DETAIL**

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

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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(1,677)	2		4
5	Telephone, TV & Radio in Resident Rooms	(2,413)	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	1,077	30		9
10	Interest and Other Investment Income	(935)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(512)	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				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	6,133	43		24
25	Fund Raising, Advertising and Promotional	(4,101)	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	(1,346)	Various		29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (3,774)		\$	30

BHF USE ONLY					
48		49		50	
				51	
					52

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	99,677	Various	34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ 99,677		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ 95,903		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	<b>TOTAL (C): (sum of lines 38-46)</b>			\$	47

Batavia Rehabilitation & Health Care Center

ID# 0047399

Report Period Beginning: 01/01/2007

Ending: 12/31/2007

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Labs-Part A	\$ (3)	43	1
2	Disallowed Special Events	(800)	43	2
3	Offset Chamber of Commerce Dues	(345)	20	3
4	Offset of Miscellaneous Revenue	(198)	21	4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
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	<b>Total</b>	(1,346)		49

## STATE OF ILLINOIS

Summary A

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

Report Period Beginning:

01/01/2007

Ending:

12/31/2007

## 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	1,467	0	2,063	0	0	0	0	0	0	0	3,530	1
2	Food Purchase	(1,677)	51	0	0	0	0	0	0	0	0	0	(1,626)	2
3	Housekeeping	0	17	0	0	0	0	0	0	0	0	0	17	3
4	Laundry	0	1	0	0	0	0	0	0	0	0	0	1	4
5	Heat and Other Utilities	0	251	0	0	0	0	0	0	0	0	0	251	5
6	Maintenance	0	2,044	0	14	0	0	0	0	0	0	0	2,058	6
7	Other (specify):*	0	669	0	1,721	0	0	0	0	0	0	0	2,390	7
8	<b>TOTAL General Services</b>	<b>(1,677)</b>	<b>4,500</b>	<b>0</b>	<b>3,798</b>	<b>0</b>	<b>6,621</b>	<b>8</b>						
	<b>B. Health Care and Programs</b>													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	3,879	0	2,424	0	0	0	0	0	0	0	6,303	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	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	862	0	2,017	0	0	0	0	0	0	0	2,879	15
16	<b>TOTAL Health Care and Programs</b>	<b>0</b>	<b>4,741</b>	<b>0</b>	<b>4,441</b>	<b>0</b>	<b>9,182</b>	<b>16</b>						
	<b>C. General Administration</b>													
17	Administrative	0	(22,079)	0	8,427	0	0	0	0	0	0	0	(13,652)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	2,965	0	2,434	0	0	0	0	0	0	0	5,399	19
20	Fees, Subscriptions & Promotions	(345)	0	642	55	0	0	0	0	0	0	0	352	20
21	Clerical & General Office Expenses	(198)	0	24,868	2,369	0	0	0	0	0	0	0	27,039	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	286	0	0	0	0	0	0	0	0	286	23
24	Travel and Seminar	0	0	455	0	0	0	0	0	0	0	0	455	24
25	Other Admin. Staff Transportation	0	0	1,649	1,317	0	0	0	0	0	0	0	2,966	25
26	Insurance-Prop.Liab.Malpractice	0	0	671	0	0	0	0	0	0	0	0	671	26
27	Other (specify):*	0	0	7,110	7,029	0	0	0	0	0	0	0	14,139	27
28	<b>TOTAL General Administration</b>	<b>(543)</b>	<b>(19,114)</b>	<b>35,681</b>	<b>21,631</b>	<b>0</b>	<b>37,655</b>	<b>28</b>						
29	<b>TOTAL Operating Expense</b> <b>(sum of lines 8,16 &amp; 28)</b>	<b>(2,220)</b>	<b>(9,873)</b>	<b>35,681</b>	<b>29,870</b>	<b>0</b>	<b>53,458</b>	<b>29</b>						

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Batavia Rehabilitation & Health Care Center # 0047399 Report Period Beginning: 01/01/2007 Ending: 12/31/2007

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	1,077	0	1,741	995	0	0	0	0	0	0	0	3,813	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(935)	0	3,027	37,165	0	0	0	0	0	0	0	39,257	32
33	Real Estate Taxes	0	0	574	0	0	0	0	0	0	0	0	574	33
34	Rent-Facility & Grounds	0	0	35	0	0	0	0	0	0	0	0	35	34
35	Rent-Equipment & Vehicles	0	0	462	0	0	0	0	0	0	0	0	462	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	<b>TOTAL Ownership</b>	<b>142</b>	<b>0</b>	<b>5,839</b>	<b>38,160</b>	<b>0</b>	<b>44,141</b>	<b>37</b>						
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
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):*	(1,696)	0	0	0	0	0	0	0	0	0	0	(1,696)	43
44	<b>TOTAL Special Cost Centers</b>	<b>(1,696)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(1,696)</b>	<b>44</b>
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	<b>(3,774)</b>	<b>(9,873)</b>	<b>41,520</b>	<b>68,030</b>	<b>0</b>	<b>95,903</b>	<b>45</b>						

**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 6E		See Attached Sch 6E		

**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)	
1	V	1 Dietary	\$	Petersen Health Care, Inc.	100.00%	\$ 1,467	\$ 1,467	1
2	V	2 Food		Petersen Health Care, Inc.	100.00%	51	51	2
3	V	3 Housekeeping		Petersen Health Care, Inc.	100.00%	17	17	3
4	V	4 Laundry		Petersen Health Care, Inc.	100.00%	1	1	4
5	V	5 Utilities		Petersen Health Care, Inc.	100.00%	251	251	5
6	V	6 Maintenance		Petersen Health Care, Inc.	100.00%	2,044	2,044	6
7	V	7 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	669	669	7
8	V	10 Nursing and Medical Records		Petersen Health Care, Inc.	100.00%	3,879	3,879	8
9	V	10A Therapy		Petersen Health Care, Inc.	100.00%	0		9
10	V	15 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	862	862	10
11	V	17 Administrative	33,000	Petersen Health Care, Inc.	100.00%	10,921	(22,079)	11
12	V	19 Professional Services		Petersen Health Care, Inc.	100.00%	2,965	2,965	12
13	V							13
14	Total		\$ 33,000			\$ 23,127	\$ * (9,873)	14

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	20 Dues, Fees, Subs and Promotions	\$	Petersen Health Care, Inc.	100.00%	\$ 642	\$	642	15
16	V	21 Clerical and General Office		Petersen Health Care, Inc.	100.00%	24,868		24,868	16
17	V	23 Inservice Training and Education		Petersen Health Care, Inc.	100.00%	286		286	17
18	V	24 Travel and Seminar		Petersen Health Care, Inc.	100.00%	455		455	18
19	V	25 Other Admin. Staff Transportation		Petersen Health Care, Inc.	100.00%	1,649		1,649	19
20	V	26 Insurance-Prop./Liab/Malpractice		Petersen Health Care, Inc.	100.00%	671		671	20
21	V	27 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	7,110		7,110	21
22	V	30 Depreciation		Petersen Health Care, Inc.	100.00%	1,741		1,741	22
23	V	32 Interest		Petersen Health Care, Inc.	100.00%	3,027		3,027	23
24	V	33 Real Estate Taxes		Petersen Health Care, Inc.	100.00%	574		574	24
25	V	34 Rent-Facility and Grounds		Petersen Health Care, Inc.	100.00%	35		35	25
26	V	35 Rent-Equipment and Vehicles		Petersen Health Care, Inc.	100.00%	462		462	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		\$			\$ 41,520	\$ *	41,520	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 Operations, LLC	100.00%	\$ 2,063	\$	2,063	15
16	V	2 Food		Petersen Health Operations, LLC	100.00%	0		0	16
17	V	3 Housekeeping		Petersen Health Operations, LLC	100.00%	0		0	17
18	V	4 Laundry		Petersen Health Operations, LLC	100.00%	0		0	18
19	V	5 Utilities		Petersen Health Operations, LLC	100.00%	0		0	19
20	V	6 Maintenance		Petersen Health Operations, LLC	100.00%	14		14	20
21	V	7 Mgmt. Allocation of Benefits		Petersen Health Operations, LLC	100.00%	1,721		1,721	21
22	V	10 Nursing and Medical Records		Petersen Health Operations, LLC	100.00%	2,424		2,424	22
23	V	10A Therapy		Petersen Health Operations, LLC	100.00%	0		0	23
24	V	15 Mgmt. Allocation of Benefits		Petersen Health Operations, LLC	100.00%	2,017		2,017	24
25	V	17 Administrative		Petersen Health Operations, LLC	100.00%	8,427		8,427	25
26	V	19 Professional Services		Petersen Health Operations, LLC	100.00%	2,434		2,434	26
27	V	20 Dues, Fees, Subs and Promotions		Petersen Health Operations, LLC	100.00%	55		55	27
28	V	21 Clerical and General Office		Petersen Health Operations, LLC	100.00%	2,369		2,369	28
29	V	23 Inservice Training and Education		Petersen Health Operations, LLC	100.00%	0		0	29
30	V	24 Travel and Seminar		Petersen Health Operations, LLC	100.00%	0		0	30
31	V	25 Other Admin. Staff Transportation		Petersen Health Operations, LLC	100.00%	1,317		1,317	31
32	V	26 Insurance-Prop./Liab/Malpractice		Petersen Health Operations, LLC	100.00%	0		0	32
33	V	27 Mgmt. Allocation of Benefits		Petersen Health Operations, LLC	100.00%	7,029		7,029	33
34	V	30 Depreciation		Petersen Health Operations, LLC	100.00%	995		995	34
35	V	32 Interest		Petersen Health Operations, LLC	100.00%	37,165		37,165	35
36	V	33 Real Estate Taxes		Petersen Health Operations, LLC	100.00%	0		0	36
37	V	34 Rent-Facility and Grounds		Petersen Health Operations, LLC	100.00%	0		0	37
38	V	35 Rent-Equipment and Vehicles		Petersen Health Operations, LLC	100.00%	0		0	38
39	Total		\$			\$ 68,030	\$ *	68,030	39

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

Facility Name & ID Number Batavia Rehabilitation & Health Care Cente # 0047399 Report Period Beginning: 01/01/2007 Ending: 12/31/2007

## VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Mark Petersen	President	Administrative	100.00	See Schedule 7A	0.72	1.31	Salary	\$ 10,921	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	\$ 10,921		13

\* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

\*\* This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number **Batavia Rehabilitation & Health Care Center**

# **0047399**

Report Period Beginning:

**01/01/2007**

Ending: **2/31/2007**

**VIII. ALLOCATION OF INDIRECT COSTS**

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES  NO

Name of Related Organization Petersen Health Care, Inc.  
 Street Address 830 W. Trailcreek Drive  
 City / State / Zip Code Peoria, IL 61614  
 Phone Number ( 309) 691-8113  
 Fax Number ( 309) 691-8622

B. Show the allocation of costs below. If necessary, please attach worksheets.

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	1	Dietary	Resident Days	1,316,550	66	\$ 110,171	\$ 109,587	17,532	\$ 1,467	1
2	2	Food	Resident Days	1,316,550	66	3,806	0	17,532	51	2
3	3	Housekeeping	Resident Days	1,316,550	66	1,250	0	17,532	17	3
4	4	Laundry	Resident Days	1,316,550	66	73	0	17,532	1	4
5	5	Utilities	Resident Days	1,316,550	66	18,812	0	17,532	251	5
6	6	Maintenance	Resident Days	1,316,550	66	153,468	113,063	17,532	2,044	6
7	7	Mgmt. Allocation of Benefits	Resident Days	1,316,550	66	50,271	0	17,532	669	7
8	10	Nursing and Medical Records	Resident Days	1,316,550	66	291,305	286,855	17,532	3,879	8
9	10A	Therapy	Resident Days	1,316,550	66	0	0	17,532	0	9
10	15	Mgmt. Allocation of Benefits	Resident Days	1,316,550	66	64,765	0	17,532	862	10
11	17	Administrative	Resident Days	1,316,550	66	820,116	820,116	17,532	10,921	11
12	19	Professional Services	Resident Days	1,316,550	66	222,628	0	17,532	2,965	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	1,316,550	66	48,243	0	17,532	642	13
14	21	Clerical and General Office	Resident Days	1,316,550	66	1,867,440	1,544,801	17,532	24,868	14
15	23	Inservice Training & Education	Resident Days	1,316,550	66	21,481	0	17,532	286	15
16	24	Travel and Seminar	Resident Days	1,316,550	66	34,177	0	17,532	455	16
17	25	Other Admin. Staff Transport.	Resident Days	1,316,550	66	123,847	0	17,532	1,649	17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	1,316,550	66	50,427	0	17,532	671	18
19	27	Mgmt. Allocation of Benefits	Resident Days	1,316,550	66	533,953	0	17,532	7,110	19
20	30	Depreciation	Resident Days	1,316,550	66	130,767	0	17,532	1,741	20
21	32	Interest	Resident Days	1,316,550	66	227,295	0	17,532	3,027	21
22	33	Real Estate Taxes	Resident Days	1,316,550	66	43,090	0	17,532	574	22
23	34	Rent-Facility and Grounds	Resident Days	1,316,550	66	2,648	0	17,532	35	23
24	35	Rent-Equipment & Vehicles	Resident Days	1,316,550	66	34,690	0	17,532	462	24
25	TOTALS					\$ 4,854,723	\$ 2,874,422		\$ 64,647	25

Facility Name & ID Number **Batavia Rehabilitation & Health Care Center**

# **0047399**

Report Period Beginning:

**01/01/2007**

Ending: **2/31/2007**

**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 Operations, LLC  
 Street Address 830 W. Trailcreek Drive  
 City / State / Zip Code Peoria, IL 61614  
 Phone Number ( 309) 691-8113  
 Fax Number ( 309) 691-8622

B. Show the allocation of costs below. If necessary, please attach worksheets.

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	1	Dietary	Resident Days	440,525	23	\$ 51,832	\$ 17,532	\$ 2,063	1
2	2	Food	Resident Days	440,525	23		17,532		2
3	3	Housekeeping	Resident Days	440,525	23		17,532		3
4	4	Laundry	Resident Days	440,525	23		17,532		4
5	5	Utilities	Resident Days	440,525	23		17,532		5
6	6	Maintenance	Resident Days	440,525	23	358	17,532	14	6
7	7	Mgmt. Allocation of Benefits	Resident Days	440,525	23	43,237	17,532	1,721	7
8	10	Nursing and Medical Records	Resident Days	440,525	23	60,910	17,532	2,424	8
9	10A	Therapy	Resident Days	440,525	23		17,532		9
10	15	Mgmt. Allocation of Benefits	Resident Days	440,525	23	50,681	17,532	2,017	10
11	17	Administrative	Resident Days	440,525	23	211,751	17,532	8,427	11
12	19	Professional Services	Resident Days	440,525	23	61,162	17,532	2,434	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	440,525	23	1,373	17,532	55	13
14	21	Clerical and General Office	Resident Days	440,525	23	59,529	17,532	2,369	14
15	23	Inservice Training & Education	Resident Days	440,525	23		17,532		15
16	24	Travel and Seminar	Resident Days	440,525	23	10	17,532		16
17	25	Other Admin. Staff Transport.	Resident Days	440,525	23	33,098	17,532	1,317	17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	440,525	23		17,532		18
19	27	Mgmt. Allocation of Benefits	Resident Days	440,525	23	176,624	17,532	7,029	19
20	30	Depreciation	Resident Days	440,525	23	24,996	17,532	995	20
21	32	Interest	Resident Days	440,525	23	933,842	17,532	37,165	21
22	33	Real Estate Taxes	Resident Days	440,525	23		17,532		22
23	34	Rent-Facility and Grounds	Resident Days	440,525	23		17,532		23
24	35	Rent-Equipment & Vehicles	Resident Days	440,525	23		17,532		24
25	TOTALS					\$ 1,709,403	\$ 324,344	\$ 68,030	25

**IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE**

**A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)**

1	2	3	4	5	6	7	8	9	10											
										Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
											YES	NO				Original	Balance			
<b>A. Directly Facility Related</b>																				
<b>Long-Term</b>																				
1	LaSalle Bank		X	Mortgage	Varies	1/19/07	\$ 300,000	\$ 298,028	12/31/13	Varies	\$ 20,491	1								
2												2								
3							Interest income offset				(935)	3								
4							Home Office Allocation-PHC				3,027	4								
5							Home Office Allocation-PHO				37,165	5								
<b>Working Capital</b>																				
6												6								
7												7								
8												8								
9	<b>TOTAL Facility Related</b>						\$ 300,000	\$ 298,028			\$ 59,748	9								
<b>B. Non-Facility Related*</b>																				
10												10								
11												11								
12												12								
13												13								
14	<b>TOTAL Non-Facility Related</b>						\$	\$			\$	14								
15	<b>TOTALS (line 9+line14)</b>						\$ 300,000	\$ 298,028			\$ 59,748	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.)

\*\* 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:** 2006 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 2006 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2006.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2006 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 2007 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.

**2006 LONG TERM CARE REAL ESTATE TAX STATEMENT**

FACILITY NAME Batavia Rehabilitation & Health Care Center COUNTY Kane

FACILITY IDPH LICENSE NUMBER 0047399

CONTACT PERSON REGARDING THIS REPORT Mark Petersen

TELEPHONE (309) 691-8113 FAX #: (309) 691-8622

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

Enter the tax index number and real estate tax assessed for 2006 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 2006.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>06-100-14-00</u>	<u>Long-Term Care Facility</u>	\$ <u>39,785.00</u>	\$ <u>39,785.00</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ <u>39,785.00</u>	\$ <u>39,785.00</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 2006 tax bills which were listed in Section A to this statement. Be sure to use the 2006 tax bill which is normally paid during 2007.

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

**X. BUILDING AND GENERAL INFORMATION:**

A. Square Feet: 14,290 B. General Construction Type: Exterior Brick Frame Wood Number of Stories 1

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

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

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

N/A

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

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

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

**XI. OWNERSHIP COSTS:**

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

**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	63	2005	1972	\$ ***	\$		\$	\$	\$
5									
6									
7	Home Office Allocation	2007		9,774			239	239	
8									
<b>Improvement Type**</b>									
9	Tile		2005	8,119		20	406	406	1,015
10	Sidewalks		2006	14,105		15	940	940	1,410
11	Roof		2006	18,900		10	1,890	1,890	2,835
12	Water Heater		2007	950		10	48	48	48
13	Backflow		2007	6,490		10	325	325	325
14	Roof		2007	7,430		20	186	186	186
15	Sprinkler System		2007	3,792		15	126	126	126
16									
17									
18									
19	Building Improvement Booked				1,577			(1,577)	
20									
21									
22	*** Note:								
23	Facility was purchased as part of a multi-facility								
24	sale. For purposes of allocating the purchase								
25	price, appraisers valued the building and land								
26	at the value of the bare land, only. The allocated								
27	amount appears on page 11 (Sch. XI (A) line 1, column 4.								
28									
29									
30									
31	2007-Home Office Allocation-Building Improvements			654			39	39	
32									
33									
34									
35									
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

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)	\$ 70,214	\$ 1,577		\$ 4,199	\$ 2,622	\$ 5,945	70

\*\*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	\$ 34,839	\$ 5,937	\$ 4,977	\$ (960)	3-20	\$ 12,263	71
72	Current Year Purchases	3,312	473	166	(307)	10	166	72
73	Fully Depreciated Assets							73
74	Home Office Allocation			2,458	2,458			74
75	TOTALS	\$ 38,151	\$ 6,410	\$ 7,601	\$ 1,191		\$ 12,429	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)	\$ 218,865	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 7,987	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 11,800	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 3,813	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 18,374	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.

**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?  YES  NO

If NO, see instructions.

		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			35			6
7	TOTAL				\$ 35			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: \$ 6,448 Description: See Schedule 14A

(Attach a schedule detailing the breakdown of movable equipment)

**C. Vehicle Rental (See instructions.)**

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18			N/A		18
19					19
20					20
21	TOTAL		\$	\$	21

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. \_\_\_\_\_ /2008 \$ \_\_\_\_\_

13. \_\_\_\_\_ /2009 \$ \_\_\_\_\_

14. \_\_\_\_\_ /2010 \$ \_\_\_\_\_

\* 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.

**Batavia Rehabilitation & Health Care Center**

**0047399**

**Period Beginning 01/01/2007**

**Period End 12/31/2007**

**Schedule 14A**

**XII. Rental Costs**

**B. Equipment**

**16. Description of rental amount for movable equipment**

Medical Equipment	\$	2,122
Dishwasher		623
Maintenance Equipment		50
Copier		3,191
Home Office Allocation		462
		<u>6,448</u>

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

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

<p><b>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?</b></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><b>2. CLASSROOM PORTION:</b></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><b>3. CLINICAL PORTION:</b></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	<b>TOTALS</b>	\$	\$	\$	\$
10	<b>SUM OF line 9, col. 1 and 2 (e)</b>	\$			

**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)	
<b>TOTAL TRAINED</b>	

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

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

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)		
			Units of Service	Cost	Units						Cost
					Units	Cost					
1	Licensed Occupational Therapist		hrs	\$		\$	\$		\$	1	
2	Licensed Speech and Language Development Therapist		hrs							2	
3	Licensed Recreational Therapist		hrs							3	
4	Licensed Physical Therapist	10A(2)	hrs				26		26	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				41		41	9	
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10	
11	Academic Education		hrs							11	
12	Exceptional Care Program									12	
13	Other (specify):									13	
14	<b>TOTAL</b>			\$		\$	\$ 67		\$ 67	14	

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

Facility Name & ID Number Batavia Rehabilitation & Health Care Center

# 0047399

Report Period Beginning: 01/01/2007

Ending:

12/31/2007

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2007

(last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ (17,133)	\$ (17,133)	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance )	382,358	382,358	3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	9,801	9,801	6
7	Other Prepaid Expenses	7,306	7,306	7
8	Accounts Receivable (owners or related parties)	(76,350)	(76,350)	8
9	Other(specify):			9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 305,982	\$ 305,982	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	124,605	110,500	13
14	Buildings, at Historical Cost		9,774	14
15	Leasehold Improvements, at Historical Cost	26,781	60,440	15
16	Equipment, at Historical Cost	38,151	38,151	16
17	Accumulated Depreciation (book methods)	(14,815)	(18,374)	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	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 174,722	\$ 200,491	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 480,704	\$ 506,473	25

		1	2	
		Operating	After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 126,004	\$ 126,004	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	22,636	22,636	30
31	Accrued Taxes Payable (excluding real estate taxes)	5,536	5,536	31
32	Accrued Real Estate Taxes(Sch.IX-B)	41,000	41,000	32
33	Accrued Interest Payable	1,862	1,862	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36	<u>Payroll Withholdings</u>	19,835	19,835	36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 216,873	\$ 216,873	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable			39
40	Mortgage Payable	298,028	298,028	40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43				43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$ 298,028	\$ 298,028	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 514,901	\$ 514,901	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ (34,197)	\$ (8,428)	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 480,704	\$ 506,473	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1 Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>(28,146)</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>	<b>Post Cost Report Audit Adjustments</b>	<b>(18,902)</b>	<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>(47,048)</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>12,851</b>	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	( )	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ <b>12,851</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>(34,197)</b>	<b>24</b> *

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

Batavia Rehabilitation & Health Care Center  
0047399  
Period Beginning 01/01/2007  
Period End 12/31/2007

**Schedule 18A**

**XVI. Statement of Changes in Equity**

**Beginning Equity Restatements:**

**Post Cost Report Audit Adjustments**

After filing the previous year's State of Illinois Financial and Statistical Report for Long-Term Care Facilities, an adjustment was made to the facility's financial records to properly state bad debt expense. Therefore, an adjustment to the current year's beginning equity is necessary to reconcile the previous year's cost report equity to the current year's equity per books. After this adjustment, cost report equity agrees to book equity on Schedule XVI.

**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	
	<b>A. Inpatient Care</b>		
1	Gross Revenue -- All Levels of Care	\$ 1,848,872	1
2	Discounts and Allowances for all Levels	690	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 1,849,562	3
	<b>B. Ancillary Revenue</b>		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$	8
	<b>C. Other Operating Revenue</b>		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	1,677	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	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 1,677	23
	<b>D. Non-Operating Revenue</b>		
24	Contributions		24
25	Interest and Other Investment Income***	935	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 935	26
	<b>E. Other Revenue (specify):****</b>		
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<u>Miscellaneous Revenue</u>	198	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 198	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 1,852,372	30

2

	Expenses	Amount	
	<b>A. Operating Expenses</b>		
31	General Services	441,115	31
32	Health Care	935,112	32
33	General Administration	349,935	33
	<b>B. Capital Expense</b>		
34	Ownership	77,129	34
	<b>C. Ancillary Expense</b>		
35	Special Cost Centers	1,737	35
36	Provider Participation Fee	34,493	36
	<b>D. Other Expenses (specify):</b>		
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 1,839,521	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	12,851	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 12,851	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. Facility is a division of a larger entity.

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

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

Facility Name & ID Number Batavia Rehabilitation & Health Care Center

# 0047399

Report Period Beginning: 01/01/2007

Ending: 12/31/2007

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	1,201	1,201	\$ 36,694	\$ 30.55	1
2	Assistant Director of Nursing	156	156	4,380	28.08	2
3	Registered Nurses	6,744	6,921	181,729	26.26	3
4	Licensed Practical Nurses	6,545	6,673	172,230	25.81	4
5	CNAs & Orderlies	26,978	27,577	313,541	11.37	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,956	2,108	27,764	13.17	9
10	Activity Assistants					10
11	Social Service Workers	2,129	2,129	32,233	15.14	11
12	Dietician					12
13	Food Service Supervisor	2,170	2,170	37,706	17.38	13
14	Head Cook					14
15	Cook Helpers/Assistants	6,602	6,859	77,582	11.31	15
16	Dishwashers					16
17	Maintenance Workers	1,731	1,731	26,027	15.04	17
18	Housekeepers	7,853	8,215	80,986	9.86	18
19	Laundry	1,814	1,844	20,055	10.88	19
20	Administrator	2,094	2,094	71,497	34.14	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	2,001	2,089	33,690	16.13	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 C: Care Plan Coord.	1,508	1,559	42,434	27.22	32
33	Other(specify) <u>Transportation</u>	2	2	18	9.00	33
34	TOTAL (lines 1 - 33)	71,484	73,328	\$ 1,158,566 *	\$ 15.80	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	Monthly	\$ 2,940	1(3)	35
36	Medical Director	Monthly	6,200	9(3)	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	447	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)		\$ 9,587		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses		\$		50
51	Licensed Practical Nurses	1,425	65,527	10(3)	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	1,425	\$ 65,527		53



Batavia Rehabilitation & Health Care Center  
0047399  
Period Beginning 01/01/2007  
Period End 12/31/2007

**Schedule 21A**

**XIX. SUPPORT SCHEDULE**

**C. Professional Services**

<b>Vendor/Payee</b>	<b>Type</b>	<b>Amount</b>
Total (agree to Schedule V, line 19, column 3)		12,268

**Home Office Allocation**

Pearl & Associates	Legal	19
Addy Bush & Assoc	Legal	10
Registered Agent Solutions	Legal	2
Heyl, Royster, Voelker & Allen	Legal	43
Duane Morris	Legal	67
Ginoli & Co.	Accountants	2,183
RSM McGladrey	Accountants	117
McGladrey & Pullen	Accountants	179
Emdeon Business Services	Computer Services	47
Advanced Answers on Demand	Computer Services	1,257
Access 2 Go	Computer Services	95
Ivans	Computer Services	421
Kemper Technology	Computer Services	197
Adminastar Federal	Computer Services	24
Logmein	Computer Services	16
E-Health Data Solutions	Computer Services	123
Miscellaneous Vendors	Computer Services	14
Julie Breedlove	Computer Services	15
Amerisearch	Employment Fees	570

Total (agree to Schedule V, line 19, column 8)	<u><u>17,667</u></u>
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Facility Name & ID Number Batavia Rehabilitation & Health Care Center# 0047399Report Period Beginning: 01/01/2007Ending: 12/31/2007**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes  
If YES, give association name and amount. IHCA-\$2,043
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes  
What was the average life used for new equipment added during this period? 10 Yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 21,001 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. \$ 34,493  
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 1,677
- (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 & Company 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 still 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 \$5,000, 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