		FOR BHF USE					

LL1

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

2010
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2010)

I. IDPH License ID Number: 0024463

Facility Name: Peterson Park Health Care Center

Address: 6141 North Pulaski Road (Number) Chicago (City) 60646 (Zip Code)

County: Cook

Telephone Number: (773) 478-2000 **Fax #** (773) 478-8408

HFS ID Number:

Date of Initial License for Current Owners: 01/01/1978

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
		X	Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Steve Lavenda **Telephone Number:** (847) 236-1111
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/10 to 12/31/10 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) (Date)
(Type or Print Name)
(Title)

Paid Preparer
(Signed) (Date)
(Print Name and Title) Cary C. Buxbaum, C.P.A.
(Firm Name & Address) Frost, Ruttenberg & Rothblatt, P.C.
111 Pfingsten Road, Suite 300 Deerfield, IL 60015
(Telephone) (847) 236-1111 Fax # (847) 236-1155

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Peterson Park Health Care Center # 0024463 Report Period Beginning: 01/01/10 Ending: 12/31/10

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 10/06/2010

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	93	Skilled (SNF)	188	42,115	1
2		Skilled Pediatric (SNF/PED)			2
3	95	Intermediate (ICF)		26,505	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	188	TOTALS	188	68,620	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	4,048	900	9,783	14,731	8
9	SNF/PED					9
10	ICF	46,551	2,433	1,324	50,308	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	50,599	3,333	11,107	65,039	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 94.78%

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 [X]

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

I. On what date did you start providing long term care at this location?
Date started 01/01/1978

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 12/86 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 92 and days of care provided 9,783

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

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

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

Tax Year: 12/31/2010 Fiscal Year: 12/31/2010

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Peterson Park Health Care Center # 0024463 Report Period Beginning: 01/01/10 Ending: 12/31/10

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	373,829	60,674	10,649	445,152		445,152		445,152			1
2	Food Purchase		430,713		430,713	(39,949)	390,764	(22)	390,742			2
3	Housekeeping	201,654	38,583		240,237		240,237	1,470	241,707			3
4	Laundry	123,569	11,420	14,728	149,717		149,717		149,717			4
5	Heat and Other Utilities			197,798	197,798		197,798	(1,982)	195,816			5
6	Maintenance	60,595	19,880	213,250	293,725		293,725	3,138	296,863			6
7	Other (specify):*											7
8	TOTAL General Services	759,647	561,270	436,425	1,757,342	(39,949)	1,717,393	2,604	1,719,997			8
	B. Health Care and Programs											
9	Medical Director			34,700	34,700		34,700		34,700			9
10	Nursing and Medical Records	2,823,253	204,714	86,804	3,114,771		3,114,771	(5,874)	3,108,897			10
10a	Therapy	78,158			78,158		78,158		78,158			10a
11	Activities	149,599	27,062	4,716	181,377		181,377		181,377			11
12	Social Services	336,342		5,039	341,381		341,381		341,381			12
13	CNA Training											13
14	Program Transportation			1,394	1,394		1,394		1,394			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	3,387,352	231,776	132,653	3,751,781		3,751,781	(5,874)	3,745,907			16
	C. General Administration											
17	Administrative	268,057		1,226,741	1,494,798		1,494,798	(1,076,700)	418,098			17
18	Directors Fees											18
19	Professional Services			138,616	138,616		138,616	7,250	145,866			19
20	Dues, Fees, Subscriptions & Promotions			144,345	144,345		144,345	(120,027)	24,318			20
21	Clerical & General Office Expenses	139,622	2,597	505,610	647,829		647,829	(244,065)	403,764			21
22	Employee Benefits & Payroll Taxes			766,727	766,727	39,949	806,676		806,676			22
23	Inservice Training & Education											23
24	Travel and Seminar			8,630	8,630		8,630	64	8,694			24
25	Other Admin. Staff Transportation			2,011	2,011		2,011	982	2,993			25
26	Insurance-Prop.Liab.Malpractice			30,529	30,529		30,529	157,660	188,189			26
27	Other (specify):*							31,815	31,815			27
28	TOTAL General Administration	407,679	2,597	2,823,209	3,233,485	39,949	3,273,434	(1,243,021)	2,030,413			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,554,678	795,643	3,392,287	8,742,608		8,742,608	(1,246,291)	7,496,317			29

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Peterson Park Health Care Center #0024463 Report Period Beginning: 01/01/10 Ending: 12/31/10

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation							280,911	280,911			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			45,647	45,647		45,647	304,326	349,973			32
33	Real Estate Taxes							196,256	196,256			33
34	Rent-Facility & Grounds			1,066,860	1,066,860		1,066,860	(1,066,860)				34
35	Rent-Equipment & Vehicles			12,501	12,501		12,501	196	12,697			35
36	Other (specify):*							27,588	27,588			36
37	**TOTAL Ownership**			1,125,008	1,125,008		1,125,008	(257,583)	867,425			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		42,907	1,386,337	1,429,244		1,429,244		1,429,244			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			102,930	102,930		102,930		102,930			42
43	Other (specify):*	23,046		303,391	326,437		326,437	(326,437)				43
44	**TOTAL Special Cost Centers**	23,046	42,907	1,792,658	1,858,611		1,858,611	(326,437)	1,532,174			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	4,577,724	838,550	6,309,953	11,726,227		11,726,227	(1,830,310)	9,895,917			45

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Peterson Park Health Care Center # 0024463 Report Period Beginning: 01/01/10 Ending: 12/31/10

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(6,590)	05		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	175,922	30		9
10	Interest and Other Investment Income	(17,516)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(220)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)	(1,491)	10		16
17	Non-Care Related Fees				17
18	Fines and Penalties	(1,365)	21		18
19	Entertainment				19
20	Contributions	(61,708)	20		20
21	Owner or Key-Man Insurance	(3,421)	26		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(177,668)	21		24
25	Fund Raising, Advertising and Promotional	(58,122)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(1,112)	21		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(200)	20		28
29	Other-Attach Schedule	(429,847)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (583,337)		$	30

BHF USE ONLY									
48		49		50		51		52	

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

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(1,246,973)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (1,246,973)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (1,830,310)		37

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Peterson Park Health Care Center

ID# 0024463

Report Period Beginning: 01/01/10

Ending: 12/31/10

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Theft & Damage Loss	$ (288)	21	1
2	Veterans' Pharmacy	(16,464)	10	2
3	Building Company Amortization	(17,372)	31	3
4	Building Company Licenses & Fees	(250)	20	4
5	Building Company Office Expenses	(505)	21	5
6	Building Company Professional Fees	(58,884)	19	6
7	Building Company Replacement Tax	(3,232)	21	7
8	Capitalized R&M	(10,934)	06	8
9	Additional R&M	7,420	06	9
10	Non-Allowable Legal	(500)	19	10
11	Bank Charges	(2,401)	21	11
12	Non-Allowable Management Fees	(303,391)	43	12
13	Non-Allowable Salaries	(23,046)	43	13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(429,847)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Peterson Park Health Care Center **#** 0024463 **Report Period Beginning:** 01/01/10 **Ending:** 12/31/10

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary													1
2	Food Purchase	(220)		198									(22)	2
3	Housekeeping			1,470									1,470	3
4	Laundry													4
5	Heat and Other Utilities	(6,590)		4,608									(1,982)	5
6	Maintenance	(3,514)		986	5,666								3,138	6
7	Other (specify):*													7
8	**TOTAL General Services**	(10,324)		7,262	5,666								2,604	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(17,955)		12,081									(5,874)	10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*													15
16	**TOTAL Health Care and Programs**	(17,955)		12,081									(5,874)	16
	C. General Administration													
17	Administrative			28,785		(1,105,485)							(1,076,700)	17
18	Directors Fees													18
19	Professional Services	(59,384)	58,884	7,750									7,250	19
20	Fees, Subscriptions & Promotions	(120,280)	250	3									(120,027)	20
21	Clerical & General Office Expenses	(186,571)	3,736	(64,362)	3,132								(244,065)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar			64									64	24
25	Other Admin. Staff Transportation			982									982	25
26	Insurance-Prop.Liab.Malpractice	(3,421)	160,496	585									157,660	26
27	Other (specify):*			27,976		3,839							31,815	27
28	**TOTAL General Administration**	(369,656)	223,366	1,783	3,132	(1,101,646)							(1,243,021)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(397,935)	223,366	21,126	8,798	(1,101,646)							(1,246,291)	29

Peterson Park Health Care Center

ID# 0024463

Report Period Beginning: 01/01/10

Ending: 12/31/10

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
50		$		1
51				2
52				3
53				4
54				5
55				6
56				7
57				8
58				9
59				10
60				11
61				12
62				13
63				14
64				15
65				16
66				17
67				18
68				19
69				20
70				21
71				22
72				23
73				24
74				25
75				26
76				27
77				28
78				29
79				30
80				31
81				32
82				33
83				34
84				35
85				36
86				37
87				38
88				39
89				40
90				41
91				42
92				43
93				44
94				45
95				46
96				47
97				48
98				49

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Peterson Park Health Care Center # 0024463 **Report Period Beginning:** 01/01/10 **Ending:** 12/31/10

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

	Capital Expense D. Ownership	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
30	Depreciation	175,922	96,013	887	8,089								280,911	30
31	Amortization of Pre-Op. & Org.	(17,372)	17,372											31
32	Interest	(17,516)	309,484	4	12,354								304,326	32
33	Real Estate Taxes		187,562		8,694								196,256	33
34	Rent-Facility & Grounds		(1,066,860)	53,984	(53,984)								(1,066,860)	34
35	Rent-Equipment & Vehicles			196									196	35
36	Other (specify):*		27,588										27,588	36
37	**TOTAL Ownership**	141,034	(428,841)	55,071	(24,847)								(257,583)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers													39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(326,437)											(326,437)	43
44	**TOTAL Special Cost Centers**	(326,437)											(326,437)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(583,337)	(205,475)	76,197	(16,049)	(1,101,646)							(1,830,310)	45

Facility Name & ID Number Peterson Park Health Care Center # 0024463 Report Period Beginning: 01/01/10 Ending: 12/31/10

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
See Attached		See Attached		See Attached		
				Peterson Park Realty		Building Co.

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rental Income	$ 1,066,860	Peterson Park Realty	100.00%	$	$ (1,066,860)	1
2	V	32	Interest	282	Peterson Park Realty	100.00%	309,766	309,484	2
3	V	31	Amortization		Peterson Park Realty	100.00%	17,372	17,372	3
4	V	30	Depreciation		Peterson Park Realty	100.00%	96,013	96,013	4
5	V	26	General Insurance		Peterson Park Realty	100.00%	160,496	160,496	5
6	V	36	MIP Expense		Peterson Park Realty	100.00%	27,588	27,588	6
7	V	20	Licenses & Fees		Peterson Park Realty	100.00%	250	250	7
8	V	21	Office Expenses		Peterson Park Realty	100.00%	504	504	8
9	V	19	Professional Fees		Peterson Park Realty	100.00%	58,884	58,884	9
10	V	21	Replacement Tax		Peterson Park Realty	100.00%	3,232	3,232	10
11	V	33	Real Estate Taxes		Peterson Park Realty	100.00%	187,562	187,562	11
12	V								12
13	V								13
14	Total			$ 1,067,142			$ 861,667	$ * (205,475)	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Peterson Park Health Care Center # 0024463 Report Period Beginning: 01/01/10 Ending: 12/31/10

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	34	Rent	$ 53,984	Legacy Real Properties	100.00%	$	$ (53,984)	15
16	V	30	Depreciation		Legacy Real Properties	100.00%	8,089	8,089	16
17	V	32	Interest		Legacy Real Properties	100.00%	12,354	12,354	17
18	V	21	Office Expense		Legacy Real Properties	100.00%	3,132	3,132	18
19	V	06	Repairs & Maintenance		Legacy Real Properties	100.00%	5,666	5,666	19
20	V	33	Real Estate Taxes		Legacy Real Properties	100.00%	8,694	8,694	20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 53,984			$ 37,935	$ * (16,049)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Peterson Park Health Care Center # 0024463 Report Period Beginning: 01/01/10 Ending: 12/31/10

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	17	Salary- Ron Shabat	$	Shabat & Associates	100.00%	$ 48,647	$ 48,647	15
16	V	27	Payroll Taxes		Shabat & Associates	100.00%	3,839	3,839	16
17	V								17
18	V	17	Management Fees	1,154,132				(1,154,132)	18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 1,154,132			$ 52,486	$ * (1,101,646)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Peterson Park Health Care Center # 0024463 Report Period Beginning: 01/01/10 Ending: 12/31/10

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	02	Food	$	Legacy Healthcare Financial Services LLC	100.00%	$ 198	$ 198	15
16	V	03	Housekeeping		Legacy Healthcare Financial Services LLC	100.00%	1,470	1,470	16
17	V	05	Utilities		Legacy Healthcare Financial Services LLC	100.00%	4,608	4,608	17
18	V	06	Maintenance		Legacy Healthcare Financial Services LLC	100.00%	986	986	18
19	V	10	Nursing		Legacy Healthcare Financial Services LLC	100.00%	12,081	12,081	19
20	V	17	Administrative Costs		Legacy Healthcare Financial Services LLC	100.00%	28,785	28,785	20
21	V	19	Professional Fees		Legacy Healthcare Financial Services LLC	100.00%	7,750	7,750	21
22	V	20	License & Permits		Legacy Healthcare Financial Services LLC	100.00%	3	3	22
23	V	21	Office Expenses		Legacy Healthcare Financial Services LLC	100.00%	150,638	150,638	23
24	V	24	Seminar & Education		Legacy Healthcare Financial Services LLC	100.00%	64	64	24
25	V	25	Auto & Travel		Legacy Healthcare Financial Services LLC	100.00%	982	982	25
26	V	26	Insurance		Legacy Healthcare Financial Services LLC	100.00%	585	585	26
27	V	27	Emp. Benefits		Legacy Healthcare Financial Services LLC	100.00%	27,976	27,976	27
28	V	30	Depreciation		Legacy Healthcare Financial Services LLC	100.00%	887	887	28
29	V	32	Interest		Legacy Healthcare Financial Services LLC	100.00%	4	4	29
30	V	34	Rent		Legacy Healthcare Financial Services LLC	100.00%	53,984	53,984	30
31	V	35	Equipment Rental		Legacy Healthcare Financial Services LLC	100.00%	196	196	31
32	V	21	Bookkeeping Fees	215,000	Legacy Healthcare Financial Services LLC	100.00%		(215,000)	32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 215,000			$ 291,197	$ * 76,197	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Peterson Park Health Care Center # 0024463 Report Period Beginning: 01/01/10 Ending: 12/31/10

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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Peterson Park Health Care Center # 0024463 Report Period Beginning: 01/01/10 Ending: 12/31/10

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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Peterson Park Health Care Center # 0024463 Report Period Beginning: 01/01/10 Ending: 12/31/10

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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

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

Facility Name & ID Number Peterson Park Health Care Center # 0024463 Report Period Beginning: 01/01/10 Ending: 12/31/10

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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Peterson Park Health Care Center # 0024463 Report Period Beginning: 01/01/10 Ending: 12/31/10

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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Peterson Park Health Care Center # 0024463 Report Period Beginning: 01/01/10 Ending: 12/31/10

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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Peterson Park Health Care Center # 0024463 Report Period Beginning: 01/01/10 Ending: 12/31/10

VII. RELATED PARTIES (continued)

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

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

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Ron Shabat	Owner	Administrative	39.00%	See Attached	30.00	85.71%	Salary/Fees	$ 191,892	17-1;17-7	1
2	Chaim Rajchenbach	Relative	Administrative	0.00%	See Attached	11.00	22.00%	Mgmt Fees	43,120	17-3	2
3	Menachem Shabat	Owner	Administrative	6.38%	See Attached	11.00	22.00%	Mgmt Fees	29,489	17-3	3
4	Chaim Shabat	Relative	Asst. Admin	0.00%	None	22.50	100.00%	Salary	14,414	17-1	4
5											5
6											6
7	Where applicable, the amounts reported on this page have been adjusted from the actual costs to reflect only amounts anticipated to be considered allowable by the										7
8	IL Dept. of HFS.										8
9											9
10											10
11											11
12											12
13								TOTAL	$ 278,915		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 Peterson Park Health Care Center # 0024463 Report Period Beginning: 01/01/10 Ending: 12/31/10

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 [X]

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

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										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	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Peterson Park Health Care Center # 0024463 Report Period Beginning: 01/01/10 Ending: 12/31/10

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization: Legacy Healthcare Financial Services, LLC
Street Address: 7040 N. Ridgeway Ave.
City / State / Zip Code: Lincolnwood, IL 60712
Phone Number: (847) 679-9797
Fax Number: (847) 679 1126

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	02	Food	Patient Days	304,581	10	$ 926	$	65,039	$ 198	1
2	3	Housekeeping	Patient Days	304,581	10	6,884	6,838	65,039	1,470	2
3	05	Utilities	Patient Days	304,581	10	21,580		65,039	4,608	3
4	06	Maintenance	Patient Days	304,581	10	4,617		65,039	986	4
5	10	Nursing	Patient Days	304,581	10	56,573	56,573	65,039	12,081	5
6	17	Administrative Costs	Patient Days	304,581	10	134,800	29,300	65,039	28,785	6
7	19	Professional Fees	Patient Days	304,581	10	36,298		65,039	7,750	7
8	20	License & Permits	Patient Days	304,581	10	15		65,039	3	8
9	21	Office Expenses	Patient Days	304,581	10	705,444	624,930	65,039	150,638	9
10	24	Seminar & Education	Patient Days	304,581	10	300		65,039	64	10
11	25	Auto & Travel	Patient Days	304,581	10	4,600		65,039	982	11
12	26	Insurance	Patient Days	304,581	10	2,741		65,039	585	12
13	27	Emp. Benefits	Patient Days	304,581	10	131,010		65,039	27,976	13
14	30	Depreciation	Bed Days Available	363,747	10	4,701		68,620	887	14
15	32	Interest	Patient Days	304,581	10	20		65,039	4	15
16	34	Rent	Patient Days	304,581	10	252,809		65,039	53,984	16
17	35	Equipment Rental	Patient Days	304,581	10	917		65,039	196	17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,364,235	$ 717,641		$ 291,197	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Peterson Park Health Care Center # 0024463 Report Period Beginning: 01/01/10 Ending: 12/31/10

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization: Legacy Real Properties LLC
Street Address: 7040 N. Ridgeway Ave.
City / State / Zip Code: Lincolnwood, IL 60712
Phone Number: (847) 679-9797
Fax Number: (847) 679 1126

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2	30	Depreciation	Bed Days Available	363,747	10	42,799		68,620	8,089	2
3	32	Interest	Patient Days	304,581	10	57,856		65,039	12,354	3
4	21	Office Expense	Patient Days	304,581	10	14,668		65,039	3,132	4
5	06	Repairs & Maintenance	Patient Days	304,581	10	26,532		65,039	5,666	5
6	33	Real Estate Taxes	Patient Days	304,581	10	40,714		65,039	8,694	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	TOTALS					$ 182,569	$		$ 37,935	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Peterson Park Health Care Center # 0024463 Report Period Beginning: 01/01/10 Ending: 12/31/10

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization: SHABAT & ASSOCIATES
Street Address: 7514 N. SKOKIE BLVD.
City / State / Zip Code: SKOKIE, IL 60077
Phone Number: ((847)982-1195
Fax Number: ((847)982-0992

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	SALARY - RON SHABAT	AVG. HOURS WORKED	35	9	56,755	56,755	30	48,647	1
2	27	PAYROLL TAXES	AVG. HOURS WORKED	35	9	4,479		30	3,839	2
3										3
4										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	TOTALS					$ 61,234	$ 56,755		$ 52,486	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Peterson Park Health Care Center # 0024463 Report Period Beginning: 01/01/10 Ending: 12/31/10

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 ☐

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

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										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	TOTALS					$	$		$	25

Facility Name & ID Number Peterson Park Health Care Center # 0024463 Report Period Beginning: 01/01/10 Ending: 12/31/10

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 ☐

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

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										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	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Peterson Park Health Care Center # 0024463 Report Period Beginning: 01/01/10 Ending: 12/31/10

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 ☐

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

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										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	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Peterson Park Health Care Center # 0024463 Report Period Beginning: 01/01/10 Ending: 12/31/10

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 ☐

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

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										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	TOTALS					$	$		$	25

Facility Name & ID Number Peterson Park Health Care Center # 0024463 Report Period Beginning: 01/01/10 Ending: 12/31/10

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 ☐

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

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										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	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Peterson Park Health Care Center # 0024463 Report Period Beginning: 01/01/10 Ending: 12/31/10

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 ☐

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

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										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	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Peterson Park Health Care Center # 0024463 Report Period Beginning: 01/01/10 Ending: 12/31/10

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** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	Heartland Bank		X	Mortgage	$39,040.00	10/16/04	$ 6,296,100	$ 5,458,340	11/01/29	0.0560	$ 309,766	1
2												2
3												3
4												4
5	See Supplemental Schedule											5
	Working Capital											
6	Bank Financial		X	Line of Credit	INT	REVOLV		37,857	REVOLV	PRIME +	42,570	6
7	Insurance Financing		X								392	7
8	See Supplemental Schedule										12,358	8
9	TOTAL Facility Related				$39,040.00		$ 6,296,100	$ 5,496,197			$ 365,086	9
	B. Non-Facility Related*											
10	Interest Income		X								(17,516)	10
11	Other Misc. Interest		X								2,685	11
12	Interest Income- Bldg Co.		X								(282)	12
13	See Supplemental Schedule											13
14	TOTAL Non-Facility Related						$	$			$ (15,113)	14
15	TOTALS (line 9+line14)						$ 6,296,100	$ 5,496,197			$ 349,973	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ 27,588 Line # 36

* 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 Peterson Park Health Care Center # 0024463 Report Period Beginning: 01/01/10 Ending: 12/31/10

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE - SUPPLEMENTAL SCHEDULE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
6												6
7	TOTAL Long-Term											7
	Working Capital											
8	Allocated From Legacy HC		X				$	$			$ 4	8
9	Allocated From Legacy RP		X								12,354	9
10												10
11												11
12												12
13												13
14	TOTAL Working Capital										12,358	14
	B. Non-Facility Related*											
15							$	$			$	15
16												16
17												17
18												18
19												19
20	TOTAL Non-Facility Related											20

* 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 Peterson Park Health Care Center # 0024463 **Report Period Beginning:** 01/01/10 **Ending:** 12/31/10

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2009 report.	$	254,470	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	229,707	2
3. Under or (over) accrual (line 2 minus line 1).	$	(24,763)	3
4. Real Estate Tax accrual used for 2010 report. (Detail and explain your calculation of this accrual on the lines below.)	$	221,019	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.	$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** (Attach a copy of the real estate tax appeal board's decision.)	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	196,256	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2005	224,029	8
	2006	218,281	9
	2007	215,745	10
	2008	214,298	11
	2009	221,013	12

Beginning Accrual Adjusted 2010 Accrual=2009 Tax

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2009	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.** This denial must be no more than four years old at the time the cost report is filed.

2009 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Peterson Park Health Care Center COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0024463

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE (847) 236-1111 FAX #: (847) 236-1155

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

Enter the tax index number and real estate tax assessed for 2009 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 2009.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	13-02-115-052-0000	Long Term Care Property	$ 221,013.19	$ 221,013.19
2.	10-35-104-076-0000	Home Office Allocation	$ 33,030.55	$ 7,068.54
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 254,043.74	$ 228,081.73

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? X YES _____ 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 2009 tax bills which were listed in Section A to this statement. Be sure to use the 2009 tax bill which is normally paid during 2010.

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.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 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 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 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 Office of Health Finance at (217) 782-1630.

2008 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Peterson Park Health Care Center COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0024463

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE (847) 236-1111 FAX #: (847) 236-1155

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

Enter the tax index number and real estate tax assessed for 2009 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 2009.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.			$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

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 _____ 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 2009 tax bills which were listed in Section A to this statement. Be sure to use the 2009 tax bill which is normally paid during 2010.

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

Facility Name & ID Number Peterson Park Health Care Center # 0024463 Report Period Beginning: 01/01/10 Ending: 12/31/10

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 51,900 B. General Construction Type: Exterior Brick Frame _____ Number of Stories 2

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

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

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

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

None

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

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

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

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility		1986	$ 283,071	1
2	Allocated From Legacy RP			15,462	2
3	TOTALS			$ 298,533	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Peterson Park Health Care Center # 0024463 Report Period Beginning: 01/01/10 Ending: 12/31/10

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			1979	4,800		20			4,800	9
10	Various			1981	57,728		20			57,728	10
11	Various			1982	11,967		20			11,967	11
12	Various			1983	3,440		20			3,440	12
13	Various			1984	12,700		20			12,700	13
14	Various			1985	98,707		20			98,707	14
15	Various			1986	42,087		20			42,087	15
16	Various			1987	17,729		20			17,729	16
17	Various			1988	35,577		20			35,577	17
18	Various			1989	14,591		20			14,591	18
19	Various			1990	27,693		20			27,693	19
20	Various			1991	62,352		20	3,118	3,118	62,352	20
21	Various			1992	10,152		20	508	508	9,644	21
22	Various			1993	21,815		20	1,091	1,091	19,633	22
23	Various			1994	264,384		20	13,219	13,219	224,727	23
24	Various			1995	103,507		20	5,175	5,175	82,807	24
25	Various			1996	35,086		20	1,754	1,754	26,316	25
26	Various			1997	62,950		20	3,148	3,148	44,062	26
27	Various			1998	49,698		20	2,485	2,485	32,303	27
28	Various			1999	87,532		20	4,377	4,377	52,516	28
29	Various			2000	189,224		20	9,461	9,461	104,465	29
30	Various			2001	73,918		20	3,696	3,696	36,958	30
31	Various			2002	350,099		20	17,505	17,505	157,604	31
32	Various			2003	78,238		20	3,912	3,912	31,295	32
33	Various			2004	66,172		20	3,309	3,309	23,160	33
34	Various			2005	53,841		20	2,692	2,692	16,152	34
35	Various			2006	50,608		20	2,530	2,530	12,652	35
36											36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Peterson Park Health Care Center # 0024463 Report Period Beginning: 01/01/10 Ending: 12/31/10

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67	Related Building Company (Pages 12F & 12G)		2,548,850	96,013		72,824	(23,189)	1,820,600	67
68	Related Party Allocations (Pages 12H & 12I)		208,521	6,108		7,859	1,751	8,956	68
69	Financial Statement Depreciation								69
70	TOTAL (lines 4 thru 69)		$ 4,643,966	$ 102,121		$ 158,662	$ 56,541	$ 3,093,221	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Peterson Park Health Care Center # 0024463 Report Period Beginning: 01/01/10 Ending: 12/31/10

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 4,643,966	$ 102,121		$ 158,662	$ 56,541	$ 3,093,221	1
2	Concrete Dock	2007	3,500		20	175	175	700	2
3	Rehab Nursing Station	2007	11,394		20	570	570	2,279	3
4	Renovation 1St Floor Corridor And Lobby Waiting Room	2007	255,996		20	12,800	12,800	51,199	4
5	Renovation Therapy Rehab Room	2007	12,744		20	637	637	2,549	5
6	Security System	2007	6,100		20	305	305	1,220	6
7	Roof	2007	17,600		20	880	880	3,520	7
8	5 Ton Multiagua R-22 Packaged Electric High Eff.	2007	32,940		20	1,647	1,647	6,588	8
9	Cable Wiring	2007	12,500		20	625	625	2,500	9
10	Nurse Call System	2007	10,612		20	531	531	2,122	10
11	Ciculation & Hot Water Lines	2007	8,770		20	439	439	1,754	11
12	Rear Entrance Door	2007	3,308		20	165	165	662	12
13	Elevator Rehab 4 New Nylon Plated Guide Shoes	2007	3,297		20	165	165	659	13
14	Landscaping	2008	16,600		20	830	830	2,490	14
15	Awning	2008	3,500		20	175	175	525	15
16	Elevator Rehab	2008	5,500		20	275	275	825	16
17	Roof	2008	4,000		20	200	200	600	17
18	Copper Piping	2008	2,860		20	143	143	429	18
19	Cable Wiring	2008	3,850		20	193	193	578	19
20	A/C Units	2008	4,497		20	225	225	675	20
21	Gate Valves	2008	2,800		20	140	140	420	21
22	Nurse Call System	2008	11,990		20	600	600	1,799	22
23	Replace Hot Wayter And Circulation Lines	2008	3,900		20	195	195	585	23
24	Cable Wiring	2008	10,460		20	523	523	1,569	24
25	Hot Water Lines	2008	7,500		20	375	375	1,125	25
26	A/C Units With Sleeves	2008	3,951		20	198	198	593	26
27	Biuld In Wardrobe Cabinets	2008	20,641		20	1,032	1,032	3,096	27
28	Painting	2009	39,906		20	1,995	1,995	3,991	28
29	Shades, Cornices, And Panels	2009	51,425		20	2,571	2,571	5,143	29
30	Flooring & Carpeting	2009	5,410		20	271	271	541	30
31	Wallcovering, Cornices & Panels	2009	10,770		20	539	539	1,077	31
32	Vinyl Flooring	2009	5,481		20	274	274	548	32
33	Smoke Detectors	2009	7,000		20	350	350	700	33
34	TOTAL (lines 1 thru 33)		$ 5,244,768	$ 102,121		$ 188,702	$ 86,581	$ 3,196,280	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Peterson Park Health Care Center # 0024463 Report Period Beginning: 01/01/10 Ending: 12/31/10

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 5,244,768	$ 102,121		$ 188,702	$ 86,581	$ 3,196,280	1
2	Grease Traps	2009	2,790		20	140	140	279	2
3	Recondition Boiler	2009	6,405		20	320	320	641	3
4	Hot Water Line	2009	5,180		20	259	259	518	4
5	Water Heater	2009	3,650		20	183	183	365	5
6	Nurse Call System	2009	21,666		20	1,083	1,083	2,167	6
7	Hot Water And Ciculation Line	2009	5,420		20	271	271	542	7
8	Hot Water And Ciculation Pipes	2009	4,760		20	238	238	476	8
9	Drywall	2009	2,500		20	125	125	250	9
10	Copper Piping	2009	5,700		20	285	285	570	10
11	Bathroom Remodeling- Lavatorys, Lilght Fixtures, Wall Towels	2009	12,407		20	620	620	1,241	11
12	Chair Rail	2009	4,329		20	216	216	433	12
13	Drywall And Drains For 2 Bathtubs	2009	5,600		20	280	280	560	13
14	Patio	2009	10,390		20	520	520	1,039	14
15	Plumbing Repairs	2010	2,800		20	140	140	140	15
16	Locks	2010	4,481		20	224	224	224	16
17	Laundry Room Walls	2010	3,653		20	183	183	183	17
18	Drywall, Metal Studs, Tile And Convert Tub To Shower	2010	4,450		20	223	223	223	18
19	Room Signs	2010	12,108		20	605	605	605	19
20	Clinical Sinks	2010	7,121		20	356	356	356	20
21	Plumbing In Utility Room	2010	9,651		20	483	483	483	21
22	Sign	2010	13,700		20	685	685	685	22
23	Nurses Station - Panels, Boards, Granite Tops	2010	36,780		20	1,839	1,839	1,839	23
24	Rehabbing Abthroom- Architects Fees	2010	4,170		20	209	209	209	24
25	Rehabbing Bathrooms- Faucets, Lighting, Flooring	2010	32,452		20	1,623	1,623	1,623	25
26	Corridor And Day Room Renovation- Cove Base, Windows, Corni	2010	172,082		20	8,604	8,604	8,604	26
27	Soiled Utility Room Renovation- Cabinets, Sinks, Cove Base	2010	23,598		20	1,180	1,180	1,180	27
28	Rehabbing Bathrooms- Walls, Lighting, Floors	2010	77,780		20	3,889	3,889	3,889	28
29	Corridor Renovation- Walls, Chair Rails, Flooring	2010	172,732		20	8,637	8,637	8,637	29
30	Tiling & Wallcovering For Foyer	2010	3,549		20	177	177	177	30
31	Generator Repair	2010	2,526		20	126	126	126	31
32	Thru The Wall Heating & A/C Units	2010	5,626		20	281	281	281	32
33	Sink And Faucets	2010	3,270		20	164	164	164	33
34	TOTAL (lines 1 thru 33)		$ 5,928,094	$ 102,121		$ 222,868	$ 120,747	$ 3,234,986	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Peterson Park Health Care Center # 0024463 Report Period Beginning: 01/01/10 Ending: 12/31/10

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 5,928,094	$ 102,121		$ 222,868	$ 120,747	$ 3,234,986	1
2	Tiling, Painting And Remodeling Social Room, Hallway & Office	2010	15,730		20	787	787	787	2
3	Drywall	2010	3,920		20	196	196	196	3
4	Change Locks	2010	4,481		20	224	224	224	4
5	Remodel Public Bathrooms- Flooring, Walls, Toilet, Lighting	2010	7,503		20	375	375	375	5
6	Shut Off Valve And Access Panels In Soiled Utility Room	2010	3,994		20	200	200	200	6
7	Replace Drywall And Studs In Bathroom	2010	2,930		20	147	147	147	7
8	Replace Existing Tile And Baseboards And Painting Walls And Ce	2010	9,990		20	500	500	500	8
9	Replacing Drywall And Studs And Painting	2010	7,918		20	396	396	396	9
10	Rebuilt Ejector Pump	2010	5,400		20	270	270	270	10
11	Bathroom Restoration- Walls And Drains	2010	9,350		20	468	468	468	11
12	Radiator Heating System	2010	9,590		20	480	480	480	12
13	Handrails, Bumpers, Door Knobs	2010	4,350		20	218	218	218	13
14	Tiling & Baseboards, Walls, Ceilings, Paint	2010	12,995		20	650	650	650	14
15	Kitchen Exhaust Fan, Ducts, Electrical	2010	3,522		20	176	176	176	15
16	Painting & Sinks In Med Room	2010	6,470		20	324	324	324	16
17	Drywall, Tiling, Raising Nurse Call Switches	2010	4,050		20	203	203	203	17
18	Pump Repairs/Pump Seal Kit	2010	2,642		20	132	132	132	18
19	Roof - Drainage	2010	2,600		20	130	130	130	19
20	Drain Water Line	2010	2,800		20	140	140	140	20
21	Glass Wall/Door	2010	14,800		20	740	740	740	21
22	Emergency/Exit Doors/Door Opener	2010	4,200		20	210	210	210	22
23	Electrical & Lighting	2010	7,720		20	386	386	386	23
24	Six Windows	2010	3,000		20	150	150	150	24
25	Hot Water Tank	2010	14,680		20	734	734	734	25
26	Beauty Mirror Installation	2010	2,500		20	125	125	125	26
27	Architect Fees	2010	6,000		20	300	300	300	27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 6,101,230	$ 102,121		$ 231,525	$ 129,404	$ 3,243,643	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Peterson Park Health Care Center # 0024463 Report Period Beginning: 01/01/10 Ending: 12/31/10

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		$ 6,101,230	$ 102,121		$ 231,525	$ 129,404	$ 3,243,643	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
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16									16
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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	TOTAL (lines 1 thru 33)		$ 6,101,230	$ 102,121		$ 231,525	$ 129,404	$ 3,243,643	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Peterson Park Health Care Center # 0024463 Report Period Beginning: 01/01/10 Ending: 12/31/10

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Building Company Information								1
2	Buildings:								2
3	188 Beds	1976	2,548,850	96,013	35	72,824	(23,189)	1,820,600	3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								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
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25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34									34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Peterson Park Health Care Center # 0024463 Report Period Beginning: 01/01/10 Ending: 12/31/10

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Building Company Information Continued		$	$		$	$	$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
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23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (12F & 12G lines 1 thru 33)		$ 2,548,850	$ 96,013		$ 72,824	$ (23,189)	$ 1,820,600	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Peterson Park Health Care Center # 0024463 Report Period Beginning: 01/01/10 Ending: 12/31/10

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Related Party Information		$	$		$	$	$	1
2	Buildings:								2
3	Allocated From Legacy RP	2009	119,800	3,993	35	3,423	(570)	5,990	3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Allocated From Legacy RP	2009	68,033		20	3,402	3,402		9
10	Allocated From Legacy RP	2010	20,688		20	1,034	1,034		10
11	Depreciation- Legacy RP			2,115			(2,115)	2,966	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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Peterson Park Health Care Center # 0024463 Report Period Beginning: 01/01/10 Ending: 12/31/10

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Related Party Information Continued								1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (12H & 12I lines 1 thru 33)		$ 208,521	$ 6,108		$ 7,859	$ 1,751	$ 8,956	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Peterson Park Health Care Center # 0024463 Report Period Beginning: 01/01/10 Ending: 12/31/10

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	$ 586,489	$ 1,360	$ 40,084	$ 38,724	10	$ 428,835	71
72	Current Year Purchases	93,026	1,508	9,303	7,795	10	8,836	72
73	Fully Depreciated Assets	831,806				10	831,806	73
74								74
75	TOTALS	$ 1,511,321	$ 2,868	$ 49,386	$ 46,518		$ 1,269,477	75

D. Vehicle Depreciation (See instructions.)*

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

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 7,911,084	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 104,989	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 280,911	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 175,922	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 4,513,120	85	

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

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

G. Construction-in-Progress

	Description	Cost	
92	Hot Water System	$ 38,000	92
93			93
94			94
95		$ 38,000	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.

Facility Name & ID Number Peterson Park Health Care Center # 0024463 Report Period Beginning: 01/01/10 Ending: 12/31/10

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

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

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

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

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

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

	Fiscal Year Ending	Annual Rent
12.	/2011	$
13.	/2012	$
14.	/2013	$

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: $ 771 Description: See Attached Schedule
(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	Facility	2009 Lexus	$ 263.17	$ 3,158	17
18	Facility	2007 Saab	395.17	4,742	18
19	Facility	Lexus	335.50	4,026	19
20					20
21	TOTAL		$ 993.83	$ 11,926	21

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Peterson Park Health Care Center # 0024463 Report Period Beginning: 01/01/10 Ending: 12/31/10

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

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

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

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

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF CNAs TRAINED

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

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Peterson Park Health Care Center # 0024463 Report Period Beginning: 01/01/10 Ending: 12/31/10

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

	1	2	3	4	5	6	7	8	
	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				
1	Licensed Occupational Therapist	39 - 03	hrs	$		$ 477,969	$		$ 477,969	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			72,608			72,608	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			443,554			443,554	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 03	# of prescrpts			351,829	26,015		377,844	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): See Supplemental					40,377	16,892		57,269	13
14	TOTAL			$		$ 1,386,337	$ 42,907		$ 1,429,244	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

STATE OF ILLINOIS

Facility Name & ID Number Peterson Park Health Care Center # 0024463 Report Period Beginning: 01/01/10 Ending: 12/31/10

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/10 (last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 6,229	$ 12,095	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,966,592	1,966,592	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	81,170	206,085	6
7	Other Prepaid Expenses	58,792	58,792	7
8	Accounts Receivable (owners or related parties)	1,930,910	7,577,850	8
9	Other(specify): See Attached Schedule	230,494	581,515	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 4,274,187	$ 10,402,929	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		102,484	13
14	Buildings, at Historical Cost		2,548,850	14
15	Leasehold Improvements, at Historical Cost		3,002,183	15
16	Equipment, at Historical Cost		1,654,157	16
17	Accumulated Depreciation (book methods)		(4,719,022)	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): See Attached Schedule		161,876	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$	$ 2,750,528	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 4,274,187	$ 13,153,457	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 783,709	$ 789,460	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	37,857	37,857	29
30	Accrued Salaries Payable	624,338	624,338	30
31	Accrued Taxes Payable (excluding real estate taxes)	69,812	69,812	31
32	Accrued Real Estate Taxes(Sch.IX-B)		221,019	32
33	Accrued Interest Payable		25,475	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached Schedule	1,273	1,520,886	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,516,989	$ 3,288,847	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		5,458,340	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Attached Schedule			43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$ 5,458,340	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,516,989	$ 8,747,187	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 2,757,198	$ 4,406,270	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 4,274,187	$ 13,153,457	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

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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.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 12,756,176	1
2	Discounts and Allowances for all Levels	(1,483,461)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 11,272,715	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,457,613	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 1,457,613	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		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	350,157	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	24,359	20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 374,516	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	17,516	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 17,516	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	183,369	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 183,369	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 13,305,729	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,757,342	31
32	Health Care	3,751,781	32
33	General Administration	3,233,485	33
	B. Capital Expense		
34	Ownership	1,125,008	34
	C. Ancillary Expense		
35	Special Cost Centers	1,755,681	35
36	Provider Participation Fee	102,930	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 11,726,227	40
41	**Income before Income Taxes (line 30 minus line 40)****	1,579,502	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 1,579,502	43

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

** **Does this agree with taxable income (loss) per Federal Income Tax Return?** Not Complete **If not, please attach a reconciliation.**

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

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

Facility Name & ID Number Peterson Park Health Care Center # 0024463 Report Period Beginning: 01/01/10 Ending: 12/31/10

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,177,693	1
2	Restatements (describe):		2
3	Rounding	3	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,177,696	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	1,579,502	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)**	$ 1,579,502	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)**	$ 2,757,198	24 *

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Peterson Park Health Care Center # 0024463 Report Period Beginning: 01/01/10 Ending: 12/31/10

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

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,015	2,214	$ 152,287	$ 68.78	1
2	Assistant Director of Nursing	2,086	2,195	78,323	35.68	2
3	Registered Nurses	37,577	41,594	1,212,424	29.15	3
4	Licensed Practical Nurses	3,670	4,112	102,745	24.99	4
5	CNAs & Orderlies	93,993	101,800	1,135,331	11.15	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	3,569	3,960	78,158	19.74	8
9	Activity Director	1,881	2,216	29,669	13.39	9
10	Activity Assistants	10,155	11,170	119,930	10.74	10
11	Social Service Workers	16,674	18,666	336,342	18.02	11
12	Dietician	2,331	2,503	71,528	28.58	12
13	Food Service Supervisor	1,723	2,010	33,631	16.73	13
14	Head Cook					14
15	Cook Helpers/Assistants	19,433	21,343	268,670	12.59	15
16	Dishwashers					16
17	Maintenance Workers	3,751	4,165	60,595	14.55	17
18	Housekeepers	16,828	18,531	201,654	10.88	18
19	Laundry	8,954	10,146	123,569	12.18	19
20	Administrator	2,080	2,080	110,408	53.08	20
21	Assistant Administrator	1,170	1,170	14,414	12.32	21
22	Other Administrative	2,080	2,080	143,235	68.86	22
23	Office Manager					23
24	Clerical	10,401	11,401	139,622	12.25	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	5,607	6,221	142,143	22.85	31
32	Other Health Care(specify)					32
33	Other(specify) See Supplemental	2,080	2,080	23,046	11.08	33
34	TOTAL (lines 1 - 33)	248,058	271,657	$ 4,577,724 *	$ 16.85	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	238	$ 10,649	01-03	35
36	Medical Director	Monthly	34,700	09-03	36
37	Medical Records Consultant	32	764	10-03	37
38	Nurse Consultant	339	16,930	10-03	38
39	Pharmacist Consultant	Monthly	9,024	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	Monthly	4,716	11-03	44
45	Social Service Consultant	87	5,039	12-03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	696	$ 81,822		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	3,307	$ 60,086	10-03	50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	3,307	$ 60,086		53

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Ronald Shabat	Administrative	43.17%	$ 143,245
Alicia Oshinski	Administrator	0.00%	110,398
Chaim Shabat	Asst. Admin	0.00%	14,414
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 268,057

B. Administrative - Other

Description	Amount
Management Fees- Shabat & Associates	$ 1,154,132
Management Fees- Menachem Shabat	29,489
Management Fees Chaim Rajchenbach	43,120
TOTAL (agree to Schedule V, line 17, col. 3)	$ 1,226,741
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
See Attached	Legal	$ 4,246
Krupnik, Bokor, Kagda & Brooks	Accounting	26,960
Richard Peelo	Cost Reporting	4,200
Lifecare Software Solutions	Computer Services	8,720
E- Health Data	Data Processing	5,448
HDSI	Data Processing	17,853
American Data	Data Processing	2,673
IIT/SourceTech	Computer Services	1,081
Jerald Freimark	Consultant	11,632
ML Enterprises	Purchasing Consult	7,594
See Supplemetal Schedule		48,210
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$ 138,616

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 76,407
Unemployment Compensation Insurance	25,739
FICA Taxes	337,294
Employee Health Insurance	251,913
Employee Meals	39,949
Illinois Municipal Retirement Fund (IMRF)*	
Chicago Head Tax	7,272
Pension Expense	41,644
Employee Meals	1,668
Other Employee Benefits	24,362
Employee Physicals	428
TOTAL (agree to Schedule V, line 22, col.8)	$ 806,676

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

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	
Health Care Worker Background Check	
(Indicate # of checks performed 435)	4,352
Patient Background Checks 267	2,668
Advertising & Promotions	58,322
Dues & Subscriptions	12,456
Licenses	4,839
Allocated From Legacy Healthcare	3
Less: Public Relations Expense	( )
Non-allowable advertising	(58,122)
Yellow page advertising	(200)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 24,318

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	8,630
Allocated From Legacy Healthcare	64
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 8,694

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Peterson Park Health Care Center # 0024463 Report Period Beginning: 01/01/10 Ending: 12/31/10

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

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
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 Peterson Park Health Care Center # 0024463 **Report Period Beginning:** 01/01/10 **Ending:** 12/31/10

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **Yes**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **IL Council on LTC $11,036; IL Assoc of HC $1,420**

(3) Did the nursing home make political contributions or payments to a political action organization? **Yes** If YES, have these costs been properly adjusted out of the cost report? **Yes**

(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 Years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **1,430** Line **10-2**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **102,930**
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. $ **39,949** Has any meal income been offset against related costs? **No** Indicate the amount. $

(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? **100% ln 14**
d. Have vehicle usage logs been maintained? **N/A**
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? **Yes**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: **N/A**

(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? **No**
Attach invoices and a summary of services for all architect and appraisal fees.