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.

2011
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2011)

I. IDPH License ID Number: 0021238

Facility Name: P. A. Peterson Center For Health

Address: 1311 Parkview Avenue (Number) Rockford (City) 61107 (Zip Code)

County: Winnebago

Telephone Number: (815)399-8832 **Fax #** (815)399-8342

HFS ID Number:

Date of Initial License for Current Owners: 00/00/41

Type of Ownership:

X	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL
X	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
			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 07/01/10 to 06/30/11 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) Steven N. Lavenda, 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 P. A. Peterson Center For Health # 0021238 Report Period Beginning: 07/01/10 Ending: 06/30/11

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1 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	129	Skilled (SNF)	129	47,085	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5	29	Sheltered Care (SC)	29	10,585	5
6		ICF/DD 16 or Less			6
7	158	TOTALS	158	57,670	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	9,967	27,825	13,101	50,893	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	9,967	27,825	13,101	50,893	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 88.25%

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)
Outpatient Therapy

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 1941

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

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 129 and days of care provided 9,886

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: 06/30/11 Fiscal Year: 06/30/11

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number P. A. Peterson Center For Health # 0021238 Report Period Beginning: 07/01/10 Ending: 06/30/11

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	520,024	41,503	38,977	600,504		600,504		600,504			1
2	Food Purchase		405,395		405,395		405,395	(14,075)	391,320			2
3	Housekeeping	190,431	34,576		225,007		225,007		225,007			3
4	Laundry	16,373	2,728	242,269	261,370		261,370		261,370			4
5	Heat and Other Utilities			296,231	296,231		296,231	(13,579)	282,652			5
6	Maintenance	132,203	39,794	178,048	350,045		350,045	(1,389)	348,656			6
7	Other (specify):*							2,656	2,656			7
8	**TOTAL General Services**	859,031	523,996	755,525	2,138,552		2,138,552	(26,387)	2,112,165			8
	B. Health Care and Programs											
9	Medical Director			27,253	27,253		27,253		27,253			9
10	Nursing and Medical Records	3,394,807	144,834	17,497	3,557,138		3,557,138	(30,126)	3,527,012			10
10a	Therapy											10a
11	Activities	131,167	3,912		135,079		135,079		135,079			11
12	Social Services	191,272		401	191,673		191,673		191,673			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	3,717,246	148,746	45,151	3,911,143		3,911,143	(30,126)	3,881,017			16
	C. General Administration											
17	Administrative	146,776			146,776		146,776	645,163	791,939			17
18	Directors Fees											18
19	Professional Services			1,211,371	1,211,371	(4,049)	1,207,322	(1,028,623)	178,699			19
20	Dues, Fees, Subscriptions & Promotions			88,553	88,553		88,553	(47,302)	41,251			20
21	Clerical & General Office Expenses	342,394	21,149	210,149	573,692		573,692	38,310	612,002			21
22	Employee Benefits & Payroll Taxes			1,267,514	1,267,514		1,267,514	131,850	1,399,364			22
23	Inservice Training & Education											23
24	Travel and Seminar			22,860	22,860		22,860	11,553	34,413			24
25	Other Admin. Staff Transportation			10,189	10,189		10,189	14,505	24,694			25
26	Insurance-Prop.Liab.Malpractice			166,036	166,036		166,036	19,449	185,485			26
27	Other (specify):*											27
28	**TOTAL General Administration**	489,170	21,149	2,976,672	3,486,991	(4,049)	3,482,942	(215,095)	3,267,847			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	5,065,447	693,891	3,777,348	9,536,686	(4,049)	9,532,637	(271,608)	9,261,029			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 P. A. Peterson Center For Health #0021238 Report Period Beginning: 07/01/10 Ending: 06/30/11

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			551,460	551,460		551,460	135,585	687,045			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			221,493	221,493		221,493	16,330	237,823			32
33	Real Estate Taxes			172,333	172,333	4,049	176,382		176,382			33
34	Rent-Facility & Grounds							59,340	59,340			34
35	Rent-Equipment & Vehicles			16,744	16,744		16,744	1,831	18,575			35
36	Other (specify):*			5,636	5,636		5,636		5,636			36
37	TOTAL Ownership			967,666	967,666	4,049	971,715	213,086	1,184,801			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		566,427	1,628,828	2,195,255		2,195,255		2,195,255			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			70,627	70,627		70,627		70,627			42
43	Other (specify):*	37,711			37,711		37,711	(37,711)				43
44	TOTAL Special Cost Centers	37,711	566,427	1,699,455	2,303,593		2,303,593	(37,711)	2,265,882			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	5,103,158	1,260,318	6,444,469	12,807,945		12,807,945	(96,233)	12,711,712			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 P. A. Peterson Center For Health # 0021238 Report Period Beginning: 07/01/10 Ending: 06/30/11

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	(14,075)	02		4
5	Telephone, TV & Radio in Resident Rooms	(16,493)	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	83,288	30		9
10	Interest and Other Investment Income	(1,175)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax		02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(62,502)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(85,249)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (96,206)		$	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)	(27)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (27)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (96,233)		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

P. A. Peterson Center For Health

ID# 0021238

Report Period Beginning: 07/01/10

Ending: 06/30/11

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Marketing Professions	$ (37,711)	43	1
2	Refunds for Discounts on Supplies	(30,126)	10	2
3	Capitalized R&M	(16,196)	06	3
4	Collection Fees	(1,216)	21	4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(85,249)		49

P. A. Peterson Center For Health

ID# 0021238

Report Period Beginning: 07/01/10

Ending: 06/30/11

	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 A

Facility Name & ID Number P. A. Peterson Center For Health # 0021238 **Report Period Beginning:** 07/01/10 **Ending:** 06/30/11

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
1	Dietary													1
2	Food Purchase	(14,075)											(14,075)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities	(16,493)		2,914									(13,579)	5
6	Maintenance	(16,196)		13,273	1,534								(1,389)	6
7	Other (specify):*			2,651	5								2,656	7
8	**TOTAL General Services**	(46,764)		18,838	1,539								(26,387)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(30,126)											(30,126)	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**	(30,126)											(30,126)	16
	C. General Administration													
17	Administrative			390,877	109,978	144,308							645,163	17
18	Directors Fees													18
19	Professional Services			(667,150)	(168,902)	(192,571)							(1,028,623)	19
20	Fees, Subscriptions & Promotions	(62,502)		2,974	11,494	732							(47,302)	20
21	Clerical & General Office Expenses	(1,216)		34,061	3,407	2,058							38,310	21
22	Employee Benefits & Payroll Taxes			77,560	26,549	27,741							131,850	22
23	Inservice Training & Education													23
24	Travel and Seminar			5,172	4,332	2,049							11,553	24
25	Other Admin. Staff Transportation			7,269	980	6,256							14,505	25
26	Insurance-Prop.Liab.Malpractice			18,788	356	305							19,449	26
27	Other (specify):*													27
28	**TOTAL General Administration**	(63,718)		(130,449)	(11,806)	(9,122)							(215,095)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(140,608)		(111,611)	(10,267)	(9,122)							(271,608)	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number **P. A. Peterson Center For Health** **#** **0021238** **Report Period Beginning:** **07/01/10** **Ending:** **06/30/11**

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	83,288		43,371	6,584	2,342							135,585	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(1,175)		10,284	951	6,270							16,330	32
33	Real Estate Taxes													33
34	Rent-Facility & Grounds			56,780	2,560								59,340	34
35	Rent-Equipment & Vehicles			1,159	169	503							1,831	35
36	Other (specify):*													36
37	**TOTAL Ownership**	82,113		111,594	10,264	9,115							213,086	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):*	(37,711)											(37,711)	43
44	**TOTAL Special Cost Centers**	(37,711)											(37,711)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(96,206)		(17)	(3)	(7)							(96,233)	45

Facility Name & ID Number P. A. Peterson Center For Health # 0021238 Report Period Beginning: 07/01/10 Ending: 06/30/11

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
LSSI	100%	St. Mathews	Park Ridge	Vesper Mgmt. Corp	Des Plaines	Mgmt. Co.
				LSSI	Des Plaines	Corp. Office

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 [X] 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			$			$	$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$			$	$ *	14

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

Facility Name & ID Number P. A. Peterson Center For Health # 0021238 Report Period Beginning: 07/01/10 Ending: 06/30/11

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	Salaries & Wages	$	Lutheran Social Services of Illinois - Management Allocation	100.00%	$ 390,877	$ 390,877	15
16	V	22	Empl Benefits & Taxes		Lutheran Social Services of Illinois - Management Allocation	100.00%	77,560	77,560	16
17	V	19	Prof Fees & Contracts		Lutheran Social Services of Illinois - Management Allocation	100.00%	17,881	17,881	17
18	V	21	Supplies, Telephone,		Lutheran Social Services of Illinois - Management Allocation	100.00%	19,969	19,969	18
19	V	34	Rental of Space		Lutheran Social Services of Illinois - Management Allocation	100.00%	56,780	56,780	19
20	V	5	Utilities		Lutheran Social Services of Illinois - Management Allocation	100.00%	2,914	2,914	20
21	V	6	Bldg Repairs & Maintenance		Lutheran Social Services of Illinois - Management Allocation	100.00%	289	289	21
22	V	32	Interest		Lutheran Social Services of Illinois - Management Allocation	100.00%	10,284	10,284	22
23	V	33	Real Estate Taxes		Lutheran Social Services of Illinois - Management Allocation	100.00%			23
24	V	26	Insurance		Lutheran Social Services of Illinois - Management Allocation	100.00%	18,788	18,788	24
25	V	20	Advertising & Promotions		Lutheran Social Services of Illinois - Management Allocation	100.00%			25
26	V	25	Transportation		Lutheran Social Services of Illinois - Management Allocation	100.00%	7,269	7,269	26
27	V	35	Car Rental		Lutheran Social Services of Illinois - Management Allocation	100.00%	352	352	27
28	V	24	Conferences & Conventions		Lutheran Social Services of Illinois - Management Allocation	100.00%	5,172	5,172	28
29	V	20	Subscriptions, Dues, Awards		Lutheran Social Services of Illinois - Management Allocation	100.00%	2,974	2,974	29
30	V	6	Furniture & Fixtures		Lutheran Social Services of Illinois - Management Allocation	100.00%	1		30
31	V	6	Machinery & Equipment		Lutheran Social Services of Illinois - Management Allocation	100.00%			31
32	V	35	Equipment Rental		Lutheran Social Services of Illinois - Management Allocation	100.00%	807	807	32
33	V	6	Equipment Repair & Maint.		Lutheran Social Services of Illinois - Management Allocation	100.00%	12,984	12,984	33
34	V	20	Employee Recruitment		Lutheran Social Services of Illinois - Management Allocation	100.00%			34
35	V	7	Security & Waste Removal		Lutheran Social Services of Illinois - Management Allocation	100.00%	2,651	2,651	35
36	V	21	All Other Miscellaneous		Lutheran Social Services of Illinois - Management Allocation	100.00%	14,092	14,092	36
37	V	30	Depreciation		Lutheran Social Services of Illinois - Management Allocation	100.00%	43,371	43,371	37
38	V	19	Management Fees	685,031	Lutheran Social Services of Illinois - Management Allocation	100.00%		(685,031)	38
39	Total			$ 685,031			$ 685,015	$ * (17)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number P. A. Peterson Center For Health # 0021238 Report Period Beginning: 07/01/10 Ending: 06/30/11

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	Salaries & Wages	$	Lutheran Social Services of Illinois - Human Resource Alloc.	100.00%	$ 109,978	$ 109,978	15
16	V	22	Empl Benefits & Taxes		Lutheran Social Services of Illinois - Human Resource Alloc.	100.00%	26,549	26,549	16
17	V	19	Prof Fees & Contracts		Lutheran Social Services of Illinois - Human Resource Alloc.	100.00%	46,735	46,735	17
18	V	21	Supplies, Telephone,		Lutheran Social Services of Illinois - Human Resource Alloc.	100.00%	3,327	3,327	18
19	V	34	Rental of Space		Lutheran Social Services of Illinois - Human Resource Alloc.	100.00%	2,560	2,560	19
20	V	5	Utilities		Lutheran Social Services of Illinois - Human Resource Alloc.	100.00%			20
21	V	6	Bldg Repairs & Maintenance		Lutheran Social Services of Illinois - Human Resource Alloc.	100.00%			21
22	V	32	Interest		Lutheran Social Services of Illinois - Human Resource Alloc.	100.00%	951	951	22
23	V	33	Real Estate Taxes		Lutheran Social Services of Illinois - Human Resource Alloc.	100.00%			23
24	V	26	Insurance		Lutheran Social Services of Illinois - Human Resource Alloc.	100.00%	356	356	24
25	V	20	Advertising & Promotions		Lutheran Social Services of Illinois - Human Resource Alloc.	100.00%			25
26	V	25	Transportation		Lutheran Social Services of Illinois - Human Resource Alloc.	100.00%	980	980	26
27	V	35	Car Rental		Lutheran Social Services of Illinois - Human Resource Alloc.	100.00%	169	169	27
28	V	24	Conferences & Conventions		Lutheran Social Services of Illinois - Human Resource Alloc.	100.00%	4,332	4,332	28
29	V	20	Subscriptions, Dues, Awards		Lutheran Social Services of Illinois - Human Resource Alloc.	100.00%	768	768	29
30	V	6	Furniture & Fixtures		Lutheran Social Services of Illinois - Human Resource Alloc.	100.00%			30
31	V	6	Machinery & Equipment		Lutheran Social Services of Illinois - Human Resource Alloc.	100.00%			31
32	V	35	Equipment Rental		Lutheran Social Services of Illinois - Human Resource Alloc.	100.00%			32
33	V	6	Equipment Repair & Maint.		Lutheran Social Services of Illinois - Human Resource Alloc.	100.00%	1,534	1,534	33
34	V	20	Employee Recruitment		Lutheran Social Services of Illinois - Human Resource Alloc.	100.00%	10,726	10,726	34
35	V	7	Security & Waste Removal		Lutheran Social Services of Illinois - Human Resource Alloc.	100.00%	5	5	35
36	V	21	All Other Miscellaneous		Lutheran Social Services of Illinois - Human Resource Alloc.	100.00%	80	80	36
37	V	30	Depreciation		Lutheran Social Services of Illinois - Human Resource Alloc.	100.00%	6,584	6,584	37
38	V	19	Human Resources Allocations	215,637	Lutheran Social Services of Illinois - Human Resource Alloc.	100.00%		(215,637)	38
39	Total			$ 215,637			$ 215,634	$ * (3)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number P. A. Peterson Center For Health # 0021238 Report Period Beginning: 07/01/10 Ending: 06/30/11

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	Salaries & Wages	$	Lutheran Social Services of Illinois - Network Administration	100.00%	$ 144,308	$ 144,308	15
16	V	22	Empl Benefits & Taxes		Lutheran Social Services of Illinois - Network Administration	100.00%	27,741	27,741	16
17	V	19	Prof Fees & Contracts		Lutheran Social Services of Illinois - Network Administration	100.00%	12,354	12,354	17
18	V	21	Supplies, Telephone,		Lutheran Social Services of Illinois - Network Administration	100.00%	2,058	2,058	18
19	V	34	Rental of Space		Lutheran Social Services of Illinois - Network Administration	100.00%			19
20	V	5	Utilities		Lutheran Social Services of Illinois - Network Administration	100.00%			20
21	V	6	Bldg Repairs & Maintenance		Lutheran Social Services of Illinois - Network Administration	100.00%			21
22	V	32	Interest		Lutheran Social Services of Illinois - Network Administration	100.00%	6,270	6,270	22
23	V	33	Real Estate Taxes		Lutheran Social Services of Illinois - Network Administration	100.00%			23
24	V	26	Insurance		Lutheran Social Services of Illinois - Network Administration	100.00%	305	305	24
25	V	20	Advertising & Promotions		Lutheran Social Services of Illinois - Network Administration	100.00%	543	543	25
26	V	25	Transportation		Lutheran Social Services of Illinois - Network Administration	100.00%	6,256	6,256	26
27	V	35	Car Rental		Lutheran Social Services of Illinois - Network Administration	100.00%			27
28	V	24	Conferences & Conventions		Lutheran Social Services of Illinois - Network Administration	100.00%	2,049	2,049	28
29	V	20	Subscriptions, Dues, Awards		Lutheran Social Services of Illinois - Network Administration	100.00%	143	143	29
30	V	6	Furniture & Fixtures		Lutheran Social Services of Illinois - Network Administration	100.00%			30
31	V	6	Machinery & Equipment		Lutheran Social Services of Illinois - Network Administration	100.00%			31
32	V	35	Equipment Rental		Lutheran Social Services of Illinois - Network Administration	100.00%	503	503	32
33	V	6	Equipment Repair & Maint.		Lutheran Social Services of Illinois - Network Administration	100.00%			33
34	V	20	Employee Recruitment		Lutheran Social Services of Illinois - Network Administration	100.00%	46	46	34
35	V	7	Security & Waste Removal		Lutheran Social Services of Illinois - Network Administration	100.00%			35
36	V	21	All Other Miscellaneous		Lutheran Social Services of Illinois - Network Administration	100.00%			36
37	V	30	Depreciation		Lutheran Social Services of Illinois - Network Administration	100.00%	2,342	2,342	37
38	V	19	Service Network Allocations	204,925	Lutheran Social Services of Illinois - Network Administration	100.00%		(204,925)	38
39	Total			$ 204,925			$ 204,918	$ * (7)	39

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

Facility Name & ID Number P. A. Peterson Center For Health # 0021238 Report Period Beginning: 07/01/10 Ending: 06/30/11

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 P. A. Peterson Center For Health # 0021238 Report Period Beginning: 07/01/10 Ending: 06/30/11

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 P. A. Peterson Center For Health # 0021238 Report Period Beginning: 07/01/10 Ending: 06/30/11

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 P. A. Peterson Center For Health # 0021238 Report Period Beginning: 07/01/10 Ending: 06/30/11

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 P. A. Peterson Center For Health # 0021238 Report Period Beginning: 07/01/10 Ending: 06/30/11

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 P. A. Peterson Center For Health # 0021238 Report Period Beginning: 07/01/10 Ending: 06/30/11

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 P. A. Peterson Center For Health # 0021238 Report Period Beginning: 07/01/10 Ending: 06/30/11

VII. RELATED PARTIES

A. (Continued) Enter below the names of ALL owners and related organizations (parties) as defined in the instructions.

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
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								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number P. A. Peterson Center For Health # 0021238 Report Period Beginning: 07/01/10 Ending: 06/30/11

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									$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		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 P. A. Peterson Center For Health # 0021238 Report Period Beginning: 07/01/10 Ending: 06/30/11

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 P. A. Peterson Center For Health # 0021238 Report Period Beginning: 07/01/10 Ending: 06/30/11

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: Lutheran Social Services of Illinois
Street Address: 1001 E. Touhy Avenue, Suite 50
City / State / Zip Code: Des Plaines, Illinois 60018
Phone Number: ((847) 635-4600
Fax Number: ((847) 635-6764

	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	Salaries & Wages	Non-Capital Direct Costs	37,701,903	246	$ 3,290,879	$ 3,290,879	4,478,080	$ 390,877	1
2	22	Empl Benefits & Taxes		37,701,903	246	652,990		4,478,080	77,560	2
3	19	Prof Fees & Contracts		37,701,903	246	150,540		4,478,080	17,881	3
4	21	Supplies, Telephone,		37,701,903	246	168,123		4,478,080	19,969	4
5		Postage, Out. Printing		37,701,903	246			4,478,080		5
6	34	Rental of Space		37,701,903	246	478,040		4,478,080	56,780	6
7	5	Utilities		37,701,903	246	24,532		4,478,080	2,914	7
8	6	Bldg Repairs & Maintenance		37,701,903	246	2,429		4,478,080	289	8
9	32	Interest		37,701,903	246	86,587		4,478,080	10,284	9
10	33	Real Estate Taxes		37,701,903	246			4,478,080		10
11	26	Insurance		37,701,903	246	158,177		4,478,080	18,788	11
12	20	Advertising & Promotions		37,701,903	246			4,478,080		12
13	25	Transportation		37,701,903	246	61,200		4,478,080	7,269	13
14	35	Car Rental		37,701,903	246	2,962		4,478,080	352	14
15	24	Conferences & Conventions		37,701,903	246	43,548		4,478,080	5,172	15
16	20	Subscriptions, Dues, Awards		37,701,903	246	25,037		4,478,080	2,974	16
17	6	Furniture & Fixtures		37,701,903	246	7		4,478,080	1	17
18	6	Machinery & Equipment		37,701,903	246			4,478,080		18
19	35	Equipment Rental		37,701,903	246	6,796		4,478,080	807	19
20	6	Equipment Repair & Maint.		37,701,903	246	109,316		4,478,080	12,984	20
21	20	Employee Recruitment		37,701,903	246			4,478,080		21
22	7	Security & Waste Removal		37,701,903	246	22,318		4,478,080	2,651	22
23	21	All Other Miscellaneous		37,701,903	246	118,647		4,478,080	14,092	23
24	30	Depreciation		37,701,903	246	365,146		4,478,080	43,371	24
25	TOTALS					$ 5,767,274	$ 3,290,879		$ 685,015	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number P. A. Peterson Center For Health # 0021238 Report Period Beginning: 07/01/10 Ending: 06/30/11

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: Lutheran Social Services of Illinois
Street Address: 1001 E. Touhy Avenue, Suite 50
City / State / Zip Code: Des Plaines, Illinois 60018
Phone Number: ((847) 635-4600
Fax Number: ((847) 635-6764

	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	Salaries & Wages	Salaries & Benefits	58,973,306	231	$ 1,018,059	$ 1,018,059	6,370,707	$ 109,978	1
2	22	Empl Benefits & Taxes		58,973,306	231	245,761		6,370,707	26,549	2
3	19	Prof Fees & Contracts		58,973,306	231	432,623		6,370,707	46,735	3
4	21	Supplies, Telephone,		58,973,306	231			6,370,707		4
5		Postage, Out. Printing		58,973,306	231	30,798		6,370,707	3,327	5
6	34	Rental of Space		58,973,306	231	23,698		6,370,707	2,560	6
7	5	Utilities		58,973,306	231			6,370,707		7
8	6	Bldg Repairs & Maintenance		58,973,306	231			6,370,707		8
9	32	Interest		58,973,306	231	8,800		6,370,707	951	9
10	33	Real Estate Taxes		58,973,306	231			6,370,707		10
11	26	Insurance		58,973,306	231	3,291		6,370,707	356	11
12	20	Advertising & Promotions		58,973,306	231			6,370,707		12
13	25	Transportation		58,973,306	231	9,075		6,370,707	980	13
14	35	Car Rental		58,973,306	231	1,568		6,370,707	169	14
15	24	Conferences & Conventions		58,973,306	231	40,104		6,370,707	4,332	15
16	20	Subscriptions, Dues, Awards		58,973,306	231	7,109		6,370,707	768	16
17	6	Furniture & Fixtures		58,973,306	231			6,370,707		17
18	6	Machinery & Equipment		58,973,306	231			6,370,707		18
19	35	Equipment Rental		58,973,306	231			6,370,707		19
20	6	Equipment Repair & Maint.		58,973,306	231	14,199		6,370,707	1,534	20
21	20	Employee Recruitment		58,973,306	231	99,292		6,370,707	10,726	21
22	7	Security & Waste Removal		58,973,306	231	46		6,370,707	5	22
23	21	All Other Miscellaneous		58,973,306	231	745		6,370,707	80	23
24	30	Depreciation		58,973,306	231	60,946		6,370,707	6,584	24
25	TOTALS					$ 1,996,114	$ 1,018,059		$ 215,634	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number P. A. Peterson Center For Health # 0021238 Report Period Beginning: 07/01/10 Ending: 06/30/11

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: Lutheran Social Services of Illinois
Street Address: 1001 E. Touhy Avenue, Suite 50
City / State / Zip Code: Des Plaines, Illinois 60018
Phone Number: ((847) 635-4600
Fax Number: ((847) 635-6764

	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	Salaries & Wages	Non-Capital Direct Costs	7,856,166	22	$ 253,168	$ 253,168	4,478,080	$ 144,308	1
2	22	Empl Benefits & Taxes		7,856,166	22	48,667		4,478,080	27,741	2
3	19	Prof Fees & Contracts		7,856,166	22	21,674		4,478,080	12,354	3
4	21	Supplies, Telephone,		7,856,166	22	3,610		4,478,080	2,058	4
5		Postage, Out. Printing		7,856,166	22			4,478,080		5
6	34	Rental of Space		7,856,166	22			4,478,080		6
7	5	Utilities		7,856,166	22			4,478,080		7
8	6	Bldg Repairs & Maintenance		7,856,166	22			4,478,080		8
9	32	Interest		7,856,166	22	11,000		4,478,080	6,270	9
10	33	Real Estate Taxes		7,856,166	22			4,478,080		10
11	26	Insurance		7,856,166	22	535		4,478,080	305	11
12	20	Advertising & Promotions		7,856,166	22	952		4,478,080	543	12
13	25	Transportation		7,856,166	22	10,975		4,478,080	6,256	13
14	35	Car Rental		7,856,166	22			4,478,080		14
15	24	Conferences & Conventions		7,856,166	22	3,595		4,478,080	2,049	15
16	20	Subscriptions, Dues, Awards		7,856,166	22	250		4,478,080	143	16
17	6	Furniture & Fixtures		7,856,166	22			4,478,080		17
18	6	Machinery & Equipment		7,856,166	22			4,478,080		18
19	35	Equipment Rental		7,856,166	22	883		4,478,080	503	19
20	6	Equipment Repair & Maint.		7,856,166	22			4,478,080		20
21	20	Employee Recruitment		7,856,166	22	81		4,478,080	46	21
22	7	Security & Waste Removal		7,856,166	22			4,478,080		22
23	21	All Other Miscellaneous		7,856,166	22			4,478,080		23
24	30	Depreciation		7,856,166	22	4,109		4,478,080	2,342	24
25	TOTALS					$ 359,499	$ 253,168		$ 204,917	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number P. A. Peterson Center For Health # 0021238 Report Period Beginning: 07/01/10 Ending: 06/30/11

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 P. A. Peterson Center For Health # 0021238 Report Period Beginning: 07/01/10 Ending: 06/30/11

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 P. A. Peterson Center For Health # 0021238 Report Period Beginning: 07/01/10 Ending: 06/30/11

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 P. A. Peterson Center For Health # 0021238 Report Period Beginning: 07/01/10 Ending: 06/30/11

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 P. A. Peterson Center For Health # 0021238 Report Period Beginning: 07/01/10 Ending: 06/30/11

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 P. A. Peterson Center For Health # 0021238 Report Period Beginning: 07/01/10 Ending: 06/30/11

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 P. A. Peterson Center For Health # 0021238 Report Period Beginning: 07/01/10 Ending: 06/30/11

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	Tax Exempt Bonds		X	Refinance of 1993 Bonds		2/16/06	$ 4,338,000	$ 3,860,343	2/16/2028	0.5230	$ 221,493	1
2												2
3												3
4												4
5	See Supplemental Schedule											5
	Working Capital											
6												6
7												7
8	See Supplemental Schedule											8
9	TOTAL Facility Related						$ 4,338,000	$ 3,860,343			$ 221,493	9
	B. Non-Facility Related*											
10	Inerest Income		X								(1,175)	10
11	Allocate LSSI (Schedule VIII)		X								17,505	11
12												12
13	See Supplemental Schedule											13
14	TOTAL Non-Facility Related						$	$			$ 16,330	14
15	TOTALS (line 9+line14)						$ 4,338,000	$ 3,860,343			$ 237,823	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ N/A Line #

*** 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 P. A. Peterson Center For Health # 0021238 Report Period Beginning: 07/01/10 Ending: 06/30/11

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** 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							$	$			$	1
2												2
3												3
4												4
5												5
6												6
7	TOTAL Long-Term											7
	Working Capital											
8							$	$			$	8
9												9
10												10
11												11
12												12
13												13
14	TOTAL Working Capital											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 P. A. Peterson Center For Health # 0021238 **Report Period Beginning:** 07/01/10 **Ending:** 06/30/11

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2010 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 174,307	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.)		$ 171,929	2
3. Under or (over) accrual (line 2 minus line 1).		$ (2,378)	3
4. Real Estate Tax accrual used for 2011 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 174,711	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.**		$ 4,049	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.		$ 176,382	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2006	148,532	8
	2007	149,208	9
	2008	158,900	10
	2009	171,731	11
	2010	172,129	12

Payment is 2nd Half of 2009 - $85,866 and 1st Half of 2009 - $86,064

Ending Accruals per Client Record

FOR BHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2010	$	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.

2010 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME P. A. Peterson Center For Health COUNTY Winnebago

FACILITY IDPH LICENSE NUMBER 0021238

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 2010 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 2010.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	163B600 12-19-101-001	Long term Care Property	$ 172,128.72	$ 172,128.72
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 172,128.72	$ 172,128.72

B. **Real Estate Tax Cost Allocations**

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

If YES, attach an explanation and 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 2010 tax bills which were listed in Section A to this statement. Be sure to use the 2010 tax bill which is normally paid during 2011.

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.

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME P. A. Peterson Center For Health COUNTY Winnebago

FACILITY IDPH LICENSE NUMBER 0021238

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE ( ) FAX #: ( )

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

Enter the tax index number and real estate tax assessed for 2000 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 2000.

	(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 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

Facility Name & ID Number P. A. Peterson Center For Health # 0021238 Report Period Beginning: 07/01/10 Ending: 06/30/11

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 110,000 B. General Construction Type: Exterior Masonry Frame Steel Grids Number of Stories 3

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

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

D. Does the Operating Entity? [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	192,020	1985	$ 8,455	1
2					2
3	TOTALS	192,020		$ 8,455	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number P. A. Peterson Center For Health # 0021238 Report Period Beginning: 07/01/10 Ending: 06/30/11

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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	158		1942	1942	$ 95,858	$	40	$	$	$ 95,858	4
5			1979	1979	5,596,922		40	139,923	139,923	4,476,954	5
6											6
7											7
8											8
	Improvement Type**										
9	Various			1969	5,300		20			5,300	9
10	Various			1975	9,226		20			9,226	10
11	Various			1977	10,074		20			10,074	11
12	Various			1980	71,947		20	144	144	71,768	12
13	Various			1981	7,309		20			7,309	13
14	Various			1982	6,151		20			6,151	14
15	Various			1983	30,936		20			30,936	15
16	Various			1984	15,554		20			15,554	16
17	Various			1985	4,850		20			4,850	17
18	Various			1986	21,640		20			21,640	18
19	Various			1988	4,414		20			4,414	19
20	Various			1989	71,006		20			71,006	20
21	Various			1990	103,287		20	5,031	5,031	94,295	21
22	Various			1991	64,328		20			64,328	22
23	Various			1992	20,528		20			20,528	23
24	Various			1993	4,296		20			4,296	24
25	Various			1994	86,971		20			86,971	25
26	Various			1995	767,445		20	30,034	30,034	571,784	26
27	Various			1996	12,220		20			12,220	27
28	Various			1997	2,685		20			2,685	28
29	Various			1998	149,521		20	7,412	7,412	125,941	29
30	Various			1999	17,200		20	1	1	17,201	30
31	Various			2000	63,500		20	3,175	3,175	31,941	31
32	Various			2001	109,787		20	5,489	5,489	69,353	32
33	Various			2002	79,186		20	3,959	3,959	51,232	33
34	Various			2003	121,363		20	7,685	7,685	82,787	34
35	Various			2004	10,088		20	504	504	3,789	35
36	Various			2005	1,697,455		20	84,873		511,088	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 P. A. Peterson Center For Health # 0021238 Report Period Beginning: 07/01/10 Ending: 06/30/11

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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	Various	2006	$ 371,882	$	20	$ 18,594	$ 18,594	$ 107,575	37
38	Various	2007	1,287,268		20	64,363	64,363	334,501	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)								67
68	Related Party Allocations (Pages 12H & 12I)			52,297			(52,297)		68
69	Financial Statement Depreciation			551,460			(551,460)		69
70	TOTAL (lines 4 thru 69)		$ 10,920,197	$ 603,757		$ 371,188	$ (317,442)	$ 7,023,555	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number P. A. Peterson Center For Health # 0021238 Report Period Beginning: 07/01/10 Ending: 06/30/11

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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		$ 10,920,197	$ 603,757		$ 371,188	$ (232,569)	$ 7,023,555	1
2	Tuckpointing	2008	110,870		20	5,544	5,544	22,174	2
3	Lobby, & Dining Room Wallpaper And Cornices	2008	7,079		20	128	128	7,079	3
4	Wiring Of Blower Fans For Ventilation	2008	36,924		20	1,846	1,846	7,385	4
5	Carpet Tile & Wall Covering	2008	26,976		20	1,349	1,349	5,395	5
6	Idph Repairs- Fire Alarm System	2008	5,910		20	296	296	887	6
7	Idph Repairs- Lobby/Reception Area	2008	2,588		20	129	129	388	7
8	Phase 3 Hvac Medicare Bed Expansion	2008	53,034		20	2,652	2,652	7,955	8
9	Front Door Repairs	2008	3,400		20	170	170	510	9
10	Chiller Repair	2008	2,625		20	131	131	394	10
11	Tuckpointing On 3 Balcony Walls	2009	4,590		20	230	230	689	11
12	Wallpaper Deposit	2009	3,679		20	184	184	552	12
13	3Rd Floor Renovation-Window Treatement	2009	2,679		20	134	134	402	13
14	3Rd Floor Renovations-Wallcovering	2009	11,036		20	552	552	1,655	14
15	Phase 3 Hvac Medicare Bed Expansion	2009	28,986		20	1,449	1,449	4,348	15
16	3Rd Floor Renovations-Overbed Lights	2009	8,437		20	422	422	1,266	16
17	3Rd Floor Renovations-Paint/Wallpaper	2009	8,770		20	439	439	1,316	17
18	3Rd Floor Renovations-Signes For Resident Rooms, Bathrooms	2009	1,407		20	70	70	211	18
19	3Rd Floor Renovations-Window Treatements	2009	8,035		20	402	402	1,205	19
20	3Rd Floor Renovations-Carpet Tile	2009	47,782		20	2,389	2,389	7,167	20
21	3Rd Floor Renovations-Painting/Wallcovering	2009	14,785		20	739	739	2,218	21
22	Catwalk Over Receiving Dock	2009	81,250		20	4,063	4,063	12,188	22
23	Repair Water Main	2009	3,255		20	163	163	488	23
24	Compressor	2009	37,526		20	1,876	1,876	3,753	24
25	Catwalk Repair	2009	7,322		20	366	366	732	25
26	Prep / Paint Walls, Sand / Stain Doors	2009	14,785		20	739	739	1,479	26
27	Installation Of Nurse Call System	2009	3,156		20	158	158	316	27
28	Boiler Repairs	2009	2,896		20	145	145	290	28
29	Bronze Pump 3In Flange	2009	2,983		20	149	149	298	29
30	Water Heater Repairs	2009	2,664		20	266	266	532	30
31	Service On Fire Alarm Sytem	2009	3,900		20	195	195	390	31
32	Air Compressor	2010	4,051		20	203	203	405	32
33	Wanderguard System	2010	11,200		20	560	560	1,120	33
34	TOTAL (lines 1 thru 33)		$ 11,484,777	$ 603,757		$ 399,323	$ (204,434)	$ 7,118,739	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number P. A. Peterson Center For Health # 0021238 Report Period Beginning: 07/01/10 Ending: 06/30/11

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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		$ 11,484,777	$ 603,757		$ 399,323	$ (204,434)	$ 7,118,739	1
2	Boiler Repair	2010	10,303		20	515	515	1,030	2
3	Paving/Striping Of Parking Lot	2010	7,523		20	376	376	752	3
4	Front Railing	2010	2,574		20	129	129	257	4
5	Bathroom Repairs	2010	3,639		20	182	182	364	5
6	Refrigeration Repairs	2010	2,696		20	135	135	270	6
7	A/C Repairs	2010	3,086		20	154	154	309	7
8	Wander Guard Door Alarms-3Rd Fl	2010	5,000		20	500	500	500	8
9	Remove/Replace Damaged Guard Rail	2010	3,275		20	164	164	164	9
10	Repair Leak In Hot Water Pump	2010	2,679		20	134	134	134	10
11	Replace Radiator	2010	2,737		20	137	137	137	11
12	Install Teknofloor In 2Nd Floor Dining Room	2011	4,900		20	245	245	245	12
13	2Nd Floor Dining Room Renovations-Wallcoverings, Awnings	2011	16,068		20	803	803	803	13
14	Interior Lighting Upgrade	2011	22,147		20	1,107	1,107	1,107	14
15	Repair Hot Water Mixing Valve Nop	2011	4,527		20	226	226	226	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	TOTAL (lines 1 thru 33)		$ 11,575,931	$ 603,757		$ 404,131	$ (199,626)	$ 7,125,038	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number P. A. Peterson Center For Health # 0021238 Report Period Beginning: 07/01/10 Ending: 06/30/11

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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		$ 11,575,931	$ 603,757		$ 404,131	$ (199,626)	$ 7,125,038	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									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 11,575,931	$ 603,757		$ 404,131	$ (199,626)	$ 7,125,038	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number P. A. Peterson Center For Health # 0021238 Report Period Beginning: 07/01/10 Ending: 06/30/11

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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		$ 11,575,931	$ 603,757		$ 404,131	$ (199,626)	$ 7,125,038	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									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 11,575,931	$ 603,757		$ 404,131	$ (199,626)	$ 7,125,038	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number P. A. Peterson Center For Health # 0021238 Report Period Beginning: 07/01/10 Ending: 06/30/11

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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									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
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 P. A. Peterson Center For Health # 0021238 Report Period Beginning: 07/01/10 Ending: 06/30/11

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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
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	TOTAL (12F & 12G lines 1 thru 33)		$	$		$	$	$	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number P. A. Peterson Center For Health # 0021238 Report Period Beginning: 07/01/10 Ending: 06/30/11

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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									3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9									9
10	LSSI Allocation (Schedule VIII)			52,297			(52,297)		10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34									34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number P. A. Peterson Center For Health # 0021238 Report Period Beginning: 07/01/10 Ending: 06/30/11

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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
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	TOTAL (12H & 12I lines 1 thru 33)		$	$ 52,297		$	$ (52,297)	$	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number P. A. Peterson Center For Health # 0021238 Report Period Beginning: 07/01/10 Ending: 06/30/11

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-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	$ 2,656,813	$	$ 260,557	$ 260,557	10	$ 2,013,864	71
72	Current Year Purchases	33,966		3,042	3,042	10	3,042	72
73	Fully Depreciated Assets	741,510				10	741,510	73
74								74
75	TOTALS	$ 3,432,289	$	$ 263,599	$ 263,599		$ 2,758,415	75

D. Vehicle Costs. (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		Handicapped Bus 1991	1991	$ 38,800	$	$	$	5	$ 38,800	76
77		2006 Chevy Turtle Top Bus	2006	96,576		19,315	19,315	5	96,576	77
78										78
79										79
80	TOTALS			$ 135,376	$	$ 19,315	$ 19,315		$ 135,376	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)	$ 15,152,051	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 603,757	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 687,045	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 83,288	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 10,018,829	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	Renovation of Assisted Living - 2001	$ 880	$	$	86
87	Renovation of Assisted Living - 2001	4,363			87
88	Renovation of Assisted Living - 2001	2,129			88
89	95 Improvement CORF - 1995	30,219			89
90	Dodge Van - 1997	17,032			90
91	TOTALS	$ 54,623	$	$	91

G. Construction-in-Progress

	Description	Cost	
92	Architect Services	$ 11,664	92
93			93
94			94
95		$ 11,664	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 P. A. Peterson Center For Health # 0021238 Report Period Beginning: 07/01/10 Ending: 06/30/11

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

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

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5	Allocate LSSI (Schedule VIII)				59,340			5
6								6
7	TOTAL				$ 59,340 **			7

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.	/2012	$
13.	/2013	$
14.	/2014	$

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

9. Option to Buy: ☐ YES ☐ NO Terms: *

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

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO
16. Rental Amount for movable equipment: $ 15,486 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		$	$ 2,567	17
18	Allocate LSSI (Schedule VIII)			521	18
19					19
20					20
21	TOTAL		$	$ 3,088	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.

Facility Name & ID Number P. A. Peterson Center For Health # 0021238 Report Period Beginning: 07/01/10 Ending: 06/30/11

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 P. A. Peterson Center For Health # 0021238 Report Period Beginning: 07/01/10 Ending: 06/30/11

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

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39 - 03	hrs	$		$ 490,086	$		$ 490,086	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			147,256			147,256	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			983,704			983,704	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 02	# of prescrpts				381,126		381,126	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					7,782	185,301		193,083	13
14	TOTAL			$		$ 1,628,828	$ 566,427		$ 2,195,255	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 P. A. Peterson Center For Health # 0021238 Report Period Beginning: 07/01/10 Ending: 06/30/11

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 06/30/11 (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	$	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)			3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Attached Schedule			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost			16
17	Accumulated Depreciation (book methods)			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			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable			30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached Schedule			36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			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)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$	$	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Facility Name & ID Number P. A. Peterson Center For Health # 0021238 **Report Period Beginning:** 07/01/10 **Ending:** 06/30/11

XVI. STATEMENT OF CHANGES IN EQUITY

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number P. A. Peterson Center For Health # 0021238 Report Period Beginning: 07/01/10 Ending: 06/30/11

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	$ 12,749,865	1
2	Discounts and Allowances for all Levels	(526,980)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 12,222,885	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	734,956	6
7	Oxygen	612	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 735,568	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	2,342	13
14	Non-Patient Meals	14,075	14
15	Telephone, Television and Radio	24,283	15
16	Rental of Facility Space		16
17	Sale of Drugs	217	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	(104)	20
21	Other Medical Services	180,513	21
22	Laundry	26,369	22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 247,695	23
	D. Non-Operating Revenue		
24	Contributions	7,380	24
25	Interest and Other Investment Income***	1,175	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 8,555	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	68,537	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 68,537	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 13,283,240	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	2,138,552	31
32	Health Care	3,911,143	32
33	General Administration	3,486,991	33
	B. Capital Expense		
34	Ownership	967,666	34
	C. Ancillary Expense		
35	Special Cost Centers	2,232,966	35
36	Provider Participation Fee	70,627	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 12,807,945	40
41	**Income before Income Taxes (line 30 minus line 40)****	475,295	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 475,295	43

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

** **Does this agree with taxable income (loss) per Federal Income Tax Return? N/A 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 P. A. Peterson Center For Health # 0021238 Report Period Beginning: 07/01/10 Ending: 06/30/11

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	1,696	1,954	$ 74,456	$ 38.10	1
2	Assistant Director of Nursing	1,688	1,959	70,566	36.02	2
3	Registered Nurses	35,580	38,982	1,082,639	27.77	3
4	Licensed Practical Nurses	39,790	42,745	940,298	22.00	4
5	CNAs & Orderlies	102,018	110,363	1,226,848	11.12	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	10,636	13,159	117,466	8.93	10
11	Social Service Workers	8,290	9,513	138,860	14.60	11
12	Dietician					12
13	Food Service Supervisor	7,155	8,096	131,737	16.27	13
14	Head Cook	9,891	10,358	102,308	9.88	14
15	Cook Helpers/Assistants	30,995	32,735	285,979	8.74	15
16	Dishwashers					16
17	Maintenance Workers	7,836	8,680	132,203	15.23	17
18	Housekeepers	19,999	22,063	190,431	8.63	18
19	Laundry	1,787	1,959	16,373	8.36	19
20	Administrator	1,586	2,008	86,370	43.01	20
21	Assistant Administrator	1,793	2,008	60,406	30.08	21
22	Other Administrative					22
23	Office Manager	1,583	1,952	45,955	23.54	23
24	Clerical	18,677	20,973	296,439	14.13	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) See Supplemental	4,701	5,405	103,824	19.21	33
34	TOTAL (lines 1 - 33)	305,701	334,912	$ 5,103,158 *	$ 15.24	34

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	As Needed	$ 38,977	01-03	35
36	Medical Director	As Needed	27,253	09-03	36
37	Medical Records Consultant	As Needed	3,457	10-03	37
38	Nurse Consultant	As Needed	11,853	10-03	38
39	Pharmacist Consultant	As Needed	2,187	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				44
45	Social Service Consultant	As Needed	401	12-03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 84,128		49

C. CONTRACT NURSES

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

** See instructions.

Facility Name & ID Number P. A. Peterson Center For Health # 0021238 Report Period Beginning: 07/01/10 Ending: 06/30/11

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Peggy Holt	Administrator		$ 86,370
Christine Hintsche	Assist Administrator		60,406
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 146,776

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$

C. Professional Services

Vendor/Payee	Type	Amount
Baker Tilly Virchov Krause	Accounting Services	$ 75,000
FR&R	Accounting Services	14,760
See Attached	Legal Services	11,483
Gary Anderson & Assoc.	Architectural Services	2,328
Ivans	Computer Services	1,353
Qqest Software Systems	Computer Services	854
Allocate LSSI		1,105,593
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $5,000, attach copy of invoices.)		$ 1,211,371

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 239,155
Unemployment Compensation Insurance	25,254
FICA Taxes	365,514
Employee Health Insurance	451,267
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Disability Insurance	9,704
Life Insurance	6,364
Pension Plan	170,256
Allocate LSSI (Schedule VIII)	131,850
TOTAL (agree to Schedule V, line 22, col.8)	$ 1,399,364

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	6,496
Health Care Worker Background Check	
(Indicate # of checks performed 520)	8,368
Patient Background Checks	
Membership Dues	11,186
Allocate LSSI (Schedule VIII)	15,200
Advertising	62,502
Less: Public Relations Expense	( )
Non-allowable advertising	(62,502)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 41,250

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	22,860
Allocate LSSI (Schedule VIII)	11,553
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 34,413

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number P. A. Peterson Center For Health # 0021238 Report Period Beginning: 07/01/10 Ending: 06/30/11

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 P. A. Peterson Center For Health # 0021238 **Report Period Beginning:** 07/01/10 **Ending:** 06/30/11

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **LSN - $5,015, AAHSA - $4,460**

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report?

(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?

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **10 Yrs**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **29,546** Line **10**

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

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

(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.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **70,627**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **0** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **14,075**

(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. $
c. What percent of all travel expense relates to transportation of nurses and patients? **None**
d. Have vehicle usage logs been maintained? **Yes**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **Yes**
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. $

(17) Has an audit been performed by an independent certified public accounting firm? **Yes**
Firm Name: **Baker Tilly Virchow Krause, LLP**

(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? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.

SEE ACCOUNTANTS' COMPILATION REPORT