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.

2012
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2012)

I. IDPH License ID Number: 0024463

Facility Name: PETERSON PARK HC CTR

Address: 6141 N PULASKI RD (Number) CHICAGO (City) 60646 (Zip Code)

County: COOK

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

HFS ID Number:

Date of Initial License for Current Owners: 01/01/78

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust	X	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: SANFORD BOKOR **Telephone Number:** (847) 675-3585
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2012 to 12/31/2012 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) MENACHEM SHABAT
(Title) PARTNER

Paid Preparer

(Signed) (SEE ATTACHED ACCOUNTANTS' REPORT) (Date)
(Print Name and Title) SANFORD BOKOR, PRESIDENT
(Firm Name & Address) KRUPNICK, BOKOR, KAGDA & BROOKS, LTD, 3750 W DEVON, LINCOLNWOOD, IL 60712-1124
(Telephone) (847) 675-3585 Fax # (847) 675-5777

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**

Facility Name & ID Number PETERSON PARK HC CTR # 0024463 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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 _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	93	Skilled (SNF)	93	34,038	1
2		Skilled Pediatric (SNF/PED)			2
3	95	Intermediate (ICF)	95	34,770	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	188	TOTALS	188	68,808	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	2,761	870	8,172	11,803	8
9	SNF/PED					9
10	ICF	47,122	4,872	347	52,341	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	49,883	5,742	8,519	64,144	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 93.22%

D. How many bed-hold days during this year were paid by the Department?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

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

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

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

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 93 and days of care provided 7,741

Medicare Intermediary NATIONAL GOVERNMENT SERVICES

IV. ACCOUNTING BASIS

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

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

Tax Year: 12/31/2012 Fiscal Year: 12/31/2012

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

Facility Name & ID Number PETERSON PARK HC CTR # 0024463 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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

	Operating Expenses	Costs Per General Ledger Salary/Wage	Supplies	Other	Total	Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	329,820	52,445	10,389	392,654		392,654		392,654			1
2	Food Purchase		495,853		495,853	(65,002)	430,851	(4,229)	426,622			2
3	Housekeeping	199,254	59,510	18,936	277,700		277,700	1,162	278,862			3
4	Laundry	143,508	48,663		192,171		192,171		192,171			4
5	Heat and Other Utilities			173,044	173,044		173,044	1,684	174,728			5
6	Maintenance	66,401	85,272	68,379	220,052		220,052	2,748	222,800			6
7	Other (specify):*			15,344	15,344		15,344		15,344			7
8	TOTAL General Services	738,983	741,743	286,092	1,766,818	(65,002)	1,701,816	1,365	1,703,181			8
	B. Health Care and Programs											
9	Medical Director			6,000	6,000		6,000		6,000			9
10	Nursing and Medical Records	2,946,337	247,360	15,659	3,209,356		3,209,356	(35,826)	3,173,530			10
10a	Therapy	174,414		69,000	243,414		243,414		243,414			10a
11	Activities	170,898	17,757	5,940	194,595		194,595		194,595			11
12	Social Services	176,162		7,312	183,474		183,474	2,519	185,993			12
13	CNA Training											13
14	Program Transportation			3,774	3,774		3,774		3,774			14
15	Other (specify):* patient personal items		5,309		5,309		5,309	1,649	6,958			15
16	TOTAL Health Care and Programs	3,467,811	270,426	107,685	3,845,922		3,845,922	(31,658)	3,814,264			16
	C. General Administration											
17	Administrative	250,969		1,940,153	2,191,122		2,191,122	(1,762,755)	428,367			17
18	Directors Fees											18
19	Professional Services			144,551	144,551		144,551	42,984	187,535			19
20	Dues, Fees, Subscriptions & Promotions			133,293	133,293		133,293	(117,545)	15,748			20
21	Clerical & General Office Expenses	258,515	55,309	362,551	676,375		676,375	(199,842)	476,533			21
22	Employee Benefits & Payroll Taxes			928,139	928,139	65,002	993,141	(2,671)	990,470			22
23	Inservice Training & Education			6,096	6,096		6,096		6,096			23
24	Travel and Seminar							211	211			24
25	Other Admin. Staff Transportation			5,722	5,722		5,722	(1,737)	3,985			25
26	Insurance-Prop.Liab.Malpractice			50,585	50,585		50,585	157,952	208,537			26
27	Other (specify):* BAD DEBT			202,100	202,100		202,100	(162,894)	39,206			27
28	TOTAL General Administration	509,484	55,309	3,773,190	4,337,983	65,002	4,402,985	(2,046,297)	2,356,688			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,716,278	1,067,478	4,166,967	9,950,723		9,950,723	(2,076,590)	7,874,133			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.
NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID#: PETERSON PARK HC CTR **#0024463** **Report Period Beginning: 01/01/2012** **Ending: 12/31/2012**

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
1	**DIETARY**			
	DIETITIAN CONSULTANT	XVIII B 35-2	10,389	
	REPAIRS & MAINTENANCE		0	
				10,389
3	**HOUSEKEEPING**			
	PROPERTY SPECIALIST - LEGACY		18,936	
			0	18,936
4	**LAUNDRY**			
	EQUIPMENT REPAIRS & MAINTENANCE		0	
			0	0
5	**HEAT & OTHER UTILITIES**			
	GAS HEAT		48,199	
	ELECTRICITY		63,219	
	WATER		53,647	
	CABLE TV - LOBBY		7,979	
			0	173,044
6	**MAINTENANCE**			
	GROUNDS MAINTENANCE		14,212	
	PAINTING & DECORATING		0	
	BUILDING REPAIRS		0	
	MAINTENANCE TRAVEL		0	
	EQUIPMENT MAINTENANCE & REPAIR		38,089	
	ELEVATOR MAINTENANCE & REPAIR		7,177	
	OUTSIDE LABOR		0	
	EXTERMINATING SERVICE		6,431	
	FIRE SERVICE		2,470	
			0	
			0	
			0	
			0	68,379
7	**OTHER**			
	SCAVENGER		15,344	
	SECURITY SERVICE		0	
			0	
			0	15,344
9	**MEDICAL DIRECTOR**			
	MEDICAL DIRECTOR FEES	XVIII B 36-2	6,000	6,000

LINE		SCHED REF		TOTAL
10	**NURSING**			
	CONTRACT NURSING	XVIII C 53-2		
	LABORATORY & XRAY EXPENSE		3,093	
	PURCHASED SERVICES		0	
	PSYCHO-SOCIAL CONSULTANT	XVIII B __-2	0	
	RESTORATIVE NURSING CONSULTANT	XVIII B 38-2	0	
	MEDICAL RECORDS CONSULTANT	XVIII B 37-2	1,568	
	PHARMACY CONSULTANT	XVIII B 39-2	10,998	
	UTILIZATION REVIEW FEES	XVIII B __-2	0	
	PHYSICIANS	XVIII B __-2	0	
	PSYCHIATRIC	XVIII B __-2	0	
	RN CONSULTANT	XVIII B 38-2	0	
			0	
			0	15,659
10a	**THERAPY**			
	PHYSICAL THERAPY SERVICES		0	
	SPEECH THERAPY SERVICES		0	
	OCCUPATIONAL THERAPY SERVICES		0	
	REHABILITATION CONSULTANT	XVIII B __-2	0	
	PHYSICAL THERAPY CONSULTANT	XVIII B 40-2	0	
	OCCUPATIONAL THERAPY CONSULTA	XVIII B 41-2	0	
	RESPIRATORY THERAPY CONSULTAN	XVIII B 42-2	0	
	SPEECH THERAPY CONSULTANT	XVIII B 43-2	0	
	NURSING		24,000	
	NURSING PROGRAM CONSULTANT		45,000	
				69,000
11	**ACTIVITIES**			
	CABLE TV - PATIENT ROOMS		0	
	ACTIVITY REHAB CONSULTANT	XVIII B 44-2	5,940	
			0	5,940
12	**SOCIAL SERVICES**			
	SOCIAL REHABILITATION SERVICES		0	
	SOCIAL REHABILITATION CONSULTAN	XVIII B 45-2	0	
	SOCIAL WORKER	XVIII B 45-2	7,312	
				7,312
13	**NURSE AIDE TRAINING**			
	NURSE AIDE TRAINING COSTS	XIII	0	0

Facility Name & ID Number PETERSON PARK HC CTR **#0024463** **Report Period Beginning:** 01/01/2012 **Ending:** 12/31/2012

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
14	**PROGRAM TRANSPORTATION**			
	PATIENT TRANSPORTATION		3,774	3,774
			0	
17	**ADMINISTRATIVE**			
	MANAGEMENT FEES	XIX B	1,940,153	1,940,153
	DIRECTORS FEES			
18	DIRECTORS FEES		0	0
19	**PROFESSIONAL SERVICES**			
	DATA PROCESSING	XIX C	66,794	
	ADMINISTRATIVE CONSULTANTS	XIX C	0	
	PROFESSIONAL FEES	XIX C	77,757	
			0	144,551
20	**FEES,SUBSCRIPTIONS,PROMOTIONS**			
	ENTERTAINMENT & MARKETING	VI 19 XIX F	0	
	ADV & PROMO-NON PATIENT RELATED	VI 25 XIX F	41,827	
	EMPLOYEE WANT ADS	XIX F	0	
	CONTRIBUTIONS	VI 20 XIX F	65,379	
	DUES & SUBSCRIPTIONS	XIX F	9,256	
	LICENSES & PERMITS	XIX F	3,375	
	PUBLIC RELATIONS-PATIENT RELATED	XIX F	0	
	ADVERTISING-YELLOW PAGES	VI 28 XIX F	0	
	TRUST FEES / FRANCHISE TAX / ETC	VI 17 XIX F	0	
	CONTRIBUTIONS - POLITICAL	VI 20 XIX F	10,649	
	HEALTH CARE WORKER BACKGROUND CHEC	XIX F	2,290	
	PATIENT BACKGROUND CHECKS	XIX F	517	
				133,293
21	**CLERICAL & GENERAL OFFICE EXPENSES**			
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)		2,015	
	EQUIPMENT REPAIR & MAINTENANCE		0	
	OUTSIDE CLERICAL SERVICES		305,854	
	PENALTIES / OVERDRAFT CHARGES	VI 18	1,124	
	HOME OFFICE EXPENSE		0	
	THEFT & DAMAGE LOSS		0	
	TELEPHONE		28,634	
	MESSENGER SERVICE		0	
	LEGACY SPECIFIC SALARY		24,924	362,551

LINE		SCHED REF		TOTAL
22	**EMPLOYEE BENEFITS & PAYROLL TAXES**			
	FICA TAXES	XIX D	353,548	
	UNEMPLOYMENT COMPENSATION	XIX D	22,809	
	WORKERS COMPENSATION INSURANC	XIX D	210,486	
	HOSPITALIZATION INSURANCE	XIX D	248,337	
	EMPLOYEE BENEFITS - OTHER	XIX D	36,095	
	EMPLOYEE PHYSICAL EXAMS	XIX D	333	
	INSURANCE - EXECUTIVE LIFE	VI 21/XIX D	2,671	
	PENSION/PROFIT SHARING PLANS	XIX D	45,544	
	CHICAGO HEAD TAX	XIX D	4,092	
	PAYROLL TAXES - LEGACY		4,224	928,139
23	**INSERVICE TRAINING & EDUCATION**			
	EDUCATION & SEMINARS		6,096	
				6,096
24	**TRAVEL & SEMINARS**			
	EDUCATION & SEMINARS	XIX G	0	
	TRAVEL	XIX G	0	
				0
25	**ADMIN. STAFF TRANSPORTATION**			
	TRANSPORTATION - STAFF		5,722	
				5,722
26	**INSURANCE - PROP. LIAB & MALPRACTICE**			
	GENERAL INSURANCE		50,585	
				50,585
27	**OTHER**			
	BAD DEBTS	VI 24	202,100	
				202,100

GRAND TOTAL COLUMN 3 OTHER **4,166,967**

PETERSON PARK HC CTR
SCHEDULES
12/31/2012

EMPLOYEE MEAL RECLASSIFICATION
PAGE 3 SCHEDULE V COLUMN 5 LINES 2 AND 22

TOTAL FOOD PURCHASE	495,853
LESS SALES TAX	(4,255)
NET FOOD	491,598
TOTAL PATIENT CENSUS	64,144
TIMES 3 MEALS PER DAY	3
TOTAL PATIENT MEALS	192,432
ADD # EMPLOYEE MEALS/DAY	80
TIMES # DAYS	366
TOTAL EMPLOYEE MEALS	29,280
PATIENT MEALS	192,432
ADD EMPLOYEE MEALS	29,280
TOTAL MEALS/YEAR	221,712
NET FOOD	491,598
DIVIDE TOTAL MEALS/YEAR	221,712
COST PER MEAL	2.22
TIMES EMPLOYEE MEALS	29,280
EMPLOYEE MEAL RECLASSIFICATION	**65,002**

Facility Name & ID Number PETERSON PARK HC CTR #0024463 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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							320,139	320,139			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			49,434	49,434		49,434	501,077	550,511			32
33	Real Estate Taxes							210,482	210,482			33
34	Rent-Facility & Grounds			1,054,741	1,054,741		1,054,741	(1,054,741)				34
35	Rent-Equipment & Vehicles			25,658	25,658		25,658	138	25,796			35
36	Other (specify):* sec 754 basis adj			8,087	8,087		8,087	24,482	32,569			36
37	TOTAL Ownership			1,137,920	1,137,920		1,137,920	1,577	1,139,497			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		290,217	784,356	1,074,573		1,074,573		1,074,573			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			616,637	616,637		616,637		616,637			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		290,217	1,400,993	1,691,210		1,691,210		1,691,210			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	4,716,278	1,357,695	6,705,880	12,779,853		12,779,853	(2,075,013)	10,704,840			45

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

Facility Name & ID Number PETERSON PARK HC CTR # 0024463 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

VI. ADJUSTMENT DETAIL

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

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	143,589	30		9
10	Interest and Other Investment Income	(6,445)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(4,255)	2		13
14	Non-Care Related Interest		32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees		20		17
18	Fines and Penalties	(1,124)	21		18
19	Entertainment		20		19
20	Contributions	(76,028)	20		20
21	Owner or Key-Man Insurance	(2,671)	22		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(202,100)	27		24
25	Fund Raising, Advertising and Promotional	(41,827)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising		20		28
29	Other-Attach Schedule	(45,163)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (236,024)		$	30

BHF USE ONLY								
48		49		50		51		52

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

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(1,838,989)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (1,838,989)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (2,075,013)		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.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

PETERSON PARK HC CTR

ID# 0024463

Report Period Beginning: 01/01/2012

Ending: 12/31/2012

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	BANK CHARGES	$ (2,015)	21	1
2	DISALLOWED TRANSPORTATION	(1,737)	25	2
3	MARKETING SALARY	(41,411)	21	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				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**	(45,163)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number PETERSON PARK HC CTR # 0024463 **Report Period Beginning:** 01/01/2012 **Ending:** 12/31/2012

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(4,255)	0	26	0	0	0	0	0	0	0	0	(4,229)	2
3	Housekeeping	0	0	1,162	0	0	0	0	0	0	0	0	1,162	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	1,684	0	0	0	0	0	0	0	0	1,684	5
6	Maintenance	0	0	2,748	0	0	0	0	0	0	0	0	2,748	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(4,255)	0	5,620	0	0	0	0	0	0	0	0	1,365	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	(35,826)	0	0	0	0	0	0	(35,826)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	2,519	0	0	0	0	0	0	2,519	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	1,649	0	0	0	0	0	0	1,649	15
16	**TOTAL Health Care and Programs**	0	0	0	0	(31,658)	0	0	0	0	0	0	(31,658)	16
	C. General Administration													
17	Administrative	0	0	(401,565)	0	25,684	(1,386,874)	0	0	0	0	0	(1,762,755)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	36,375	6,441	0	168	0	0	0	0	0	0	42,984	19
20	Fees, Subscriptions & Promotions	(117,855)	250	60	0	0	0	0	0	0	0	0	(117,545)	20
21	Clerical & General Office Expenses	(44,550)	0	(155,576)	0	284	0	0	0	0	0	0	(199,842)	21
22	Employee Benefits & Payroll Taxes	(2,671)	0	0	0	0	0	0	0	0	0	0	(2,671)	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	211	0	0	0	0	0	0	0	0	211	24
25	Other Admin. Staff Transportation	(1,737)	0	0	0	0	0	0	0	0	0	0	(1,737)	25
26	Insurance-Prop.Liab.Malpractice	0	157,213	739	0	0	0	0	0	0	0	0	157,952	26
27	Other (specify):*	(202,100)	0	37,818	0	0	1,388	0	0	0	0	0	(162,894)	27
28	**TOTAL General Administration**	(368,913)	193,838	(511,872)	0	26,136	(1,385,486)	0	0	0	0	0	(2,046,297)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(373,168)	193,838	(506,252)	0	(5,522)	(1,385,486)	0	0	0	0	0	(2,076,590)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number PETERSON PARK HC CTR # 0024463 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	143,589	172,939	1,199	2,412	0	0	0	0	0	0	0	320,139	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(6,445)	503,146	5	4,371	0	0	0	0	0	0	0	501,077	32
33	Real Estate Taxes	0	206,230	0	4,252	0	0	0	0	0	0	0	210,482	33
34	Rent-Facility & Grounds	0	(1,054,741)	12,824	(12,824)	0	0	0	0	0	0	0	(1,054,741)	34
35	Rent-Equipment & Vehicles	0	0	0	0	138	0	0	0	0	0	0	138	35
36	Other (specify):*	0	24,482	0	0	0	0	0	0	0	0	0	24,482	36
37	TOTAL Ownership	137,144	(147,944)	14,028	(1,789)	138	0	0	0	0	0	0	1,577	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(236,024)	45,894	(492,224)	(1,789)	(5,384)	(1,385,486)	0	0	0	0	0	(2,075,013)	45

Facility Name & ID Number PETERSON PARK HC CTR # 0024463 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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
CHAIM RAJCHENBACH	5.32	THE GROVE AT LINCOLN PARK	CHICAGO	GROVE HC PROP	CHICAGO	REAL ESTATE
MENACHEM SHABAT	10.64	THE GROVE OF NORTHBROOK	CHICAGO	LEGACY HC		
JACK RAJCHENBACH	9.57	ASTORIA PLACE LIVING & REHAB CENTER	CHICAGO	FINANCIAL SERV	LINCOLNWOOD	MGMT
RONALD SHABAT	69.15	THE GROVE OF EVANSTON	EVANSTON	LEGACY REAL PRO	LINCOLNWOOD	REAL ESTATE
PPA, LTD.	5.32	ELMBROOK NURSING	ELMHURST	ASTORIA HEALTH		
		CHALET LIVING & REHAB	CHICAGO	CARE PROP	CHICAGO	REAL ESTATE
		LAKEFRONT NURSING	CHICAGO	EVANSTON HC RLT	EVANSTON	REAL ESTATE

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	RENT	$ 1,054,741	PETERSON PARK REALTY		$	$ (1,054,741)	1
2	V								2
3	V	19	PROF FEES		PETERSON PARK REALTY		36,375	36,375	3
4	V	33	PROF. FEES - R/E REDUCTION		PETERSON PARK REALTY		11,377	11,377	4
5	V	20	LICENSES & FEES		PETERSON PARK REALTY		250	250	5
6	V	26	INSURANCE - GENERAL		PETERSON PARK REALTY		157,213	157,213	6
7	V	30	DEPRECIATION		PETERSON PARK REALTY		172,939	172,939	7
8	V	32	AMORT LOAN COSTS		PETERSON PARK REALTY		115,341	115,341	8
9	V	32	INTEREST		PETERSON PARK REALTY		387,805	387,805	9
10	V	33	REAL ESTATE TAXES		PETERSON PARK REALTY		194,853	194,853	10
11	V	36	INSURANCE H.U.D. (MIP)		PETERSON PARK REALTY		24,482	24,482	11
12	V								12
13	V								13
14	Total			$ 1,054,741			$ 1,100,635	$ * 45,894	14

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

Facility Name & ID Number PETERSON PARK HC CTR # 0024463 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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			THE GROVE OF LAGRANGE	LAGRANGE PARK	ELMBROOK		REAL ESTATE	1
2			THE GROVE AT THE LAKE	ZION	HEALTHCARE RLT	ELMHURST	REAL ESTATE	2
3			THE GROVE OF SKOKIE	SKOKIE	PETERSON PK RLTY	CHICAGO		3
4			PARK VILLA NURSING & REHAB	PALOS HEIGHTS	GROVE LAGRANGE		REAL ESTATE	4
5			THE VILLA AT WINDSOR PARK	CHICAGO	REALTY	LAGRANGE PK		5
6					GROVE AT THE		REAL ESTATE	6
7					LAKE REALTY	ZION		7
8					CHALET REAL		REAL ESTATE	8
9					PROPERTY	CHICAGO	REAL ESTATE	9
10					PARK VILLA RLTY	PALOS HGTS		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 PETERSON PARK HC CTR # 0024463 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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	MANAGEMENT FEES	$ 457,565	LEGACY HEALTHCARE FINANCIAL SERVICES LLC		$	$ (457,565)	15
16	V	21	OUTSIDE CLERICAL	305,854	LEGACY HEALTHCARE FINANCIAL SERVICES LLC			(305,854)	16
17	V	2	FOOD		LEGACY HEALTHCARE FINANCIAL SERVICES LLC		26	26	17
18	V	3	HOUSEKEEPING		LEGACY HEALTHCARE FINANCIAL SERVICES LLC		1,162	1,162	18
19	V	5	UTILITIES		LEGACY HEALTHCARE FINANCIAL SERVICES LLC		1,684	1,684	19
20	V	6	GROUNDS & MAINTENANCE		LEGACY HEALTHCARE FINANCIAL SERVICES LLC		2,748	2,748	20
21	V	17	MANAGEMENT FEES		LEGACY HEALTHCARE FINANCIAL SERVICES LLC		56,000	56,000	21
22	V	19	PROFESSIONAL FEES		LEGACY HEALTHCARE FINANCIAL SERVICES LLC		6,441	6,441	22
23	V	20	FEES,SUBSCRIPTIONS		LEGACY HEALTHCARE FINANCIAL SERVICES LLC		60	60	23
24	V	21	CLERICAL & GENERAL		LEGACY HEALTHCARE FINANCIAL SERVICES LLC		150,278	150,278	24
25	V	24	SEMINARS		LEGACY HEALTHCARE FINANCIAL SERVICES LLC		211	211	25
26	V	26	INSURANCE		LEGACY HEALTHCARE FINANCIAL SERVICES LLC		739	739	26
27	V	27	EMPL BENEFITS-GEN ADMIN		LEGACY HEALTHCARE FINANCIAL SERVICES LLC		21,998	21,998	27
28	V	27	EMPL BENEFITS-OWNERS		LEGACY HEALTHCARE FINANCIAL SERVICES LLC		15,820	15,820	28
29	V	30	DEPRECIATION		LEGACY HEALTHCARE FINANCIAL SERVICES LLC		1,199	1,199	29
30	V	32	INTEREST		LEGACY HEALTHCARE FINANCIAL SERVICES LLC		5	5	30
31	V	34	RENT				12,824	12,824	31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 763,419			$ 271,195	$ * (492,224)	39

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

Facility Name & ID Number PETERSON PARK HC CTR # 0024463 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	34	RENT	$ 12,824	LEGACY REAL PROPERTIES LLC		$	$ (12,824)	15
16	V	30	DEPRECIATION		LEGACY REAL PROPERTIES LLC		2,412	2,412	16
17	V	32	INTEREST EXPENSE		LEGACY REAL PROPERTIES LLC		4,371	4,371	17
18	V	33	REAL ESTATE TAXES		LEGACY REAL PROPERTIES LLC		4,252	4,252	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			$ 12,824			$ 11,035	$ * (1,789)	39

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

Facility Name & ID Number PETERSON PARK HC CTR # 0024463 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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	10	NURSE CONSULTANT	$ 48,000	PROGRESSIVE HEALTHCARE CONSULTING		$	$ (48,000)	15
16	V	10	RN SALARIES		PROGRESSIVE HEALTHCARE CONSULTING		12,174	12,174	16
17	V	12	CLERGY SALARY		PROGRESSIVE HEALTHCARE CONSULTING		2,519	2,519	17
18	V	15	EMPLOYEE BENEFITS		PROGRESSIVE HEALTHCARE CONSULTING		1,649	1,649	18
19	V	17	ADMIN		PROGRESSIVE HEALTHCARE CONSULTING		25,684	25,684	19
20	V	19	PROFESSIONAL FEES		PROGRESSIVE HEALTHCARE CONSULTING		168	168	20
21	V	21	CLERICAL AND GENERAL		PROGRESSIVE HEALTHCARE CONSULTING		284	284	21
22	V	35	AUTO RENTAL		PROGRESSIVE HEALTHCARE CONSULTING		138	138	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			$ 48,000			$ 42,616	$ * (5,384)	39

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

Facility Name & ID Number PETERSON PARK HC CTR # 0024463 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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	MANAGEMENT FEES	$ 1,482,588	SHABAT & ASSOCIATES		$	$ (1,482,588)	15
16	V	17	SALARY- RON SHABAT		SHABAT & ASSOCIATES		95,714	95,714	16
17	V	27	PAYROLL TAXES		SHABAT & ASSOCIATES		1,388	1,388	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			$ 1,482,588			$ 97,102	$ * (1,385,486)	39

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

Facility Name & ID Number PETERSON PARK HC CTR # 0024463 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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	6	PROPERTY SPECIALIST	$ 18,936	LEGACY HEALTHCARE FINANCIAL SERVICES LLC		$ 18,936	$	15
16	V	21	AR FIELD COORDINATOR	10,108	LEGACY HEALTHCARE FINANCIAL SERVICES LLC		10,108		16
17	V	21	IN-HOUSE COUNSEL	5,752	LEGACY HEALTHCARE FINANCIAL SERVICES LLC		5,752		17
18	V	21	PURCHASING DIRECTOR	4,924	LEGACY HEALTHCARE FINANCIAL SERVICES LLC		4,924		18
19	V	21	CORP IT DIRECTOR	4,140	LEGACY HEALTHCARE FINANCIAL SERVICES LLC		4,140		19
20	V	22	PAYROLL TAXES	4,224			4,224		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			$ 48,084			$ 48,084	$ *	39

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

Facility Name & ID Number PETERSON PARK HC CTR # 0024463 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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	RONALD SHABAT	OWNER	Administrative	69.15	SEE ATTACHED			Salary/Fees	$ 200,000	17-1;17-7	1
2	CHAIM RAJCHENBACH	RELATIVE	Administrative	5.32	SEE ATTACHED			SALARY	28,000	17-3	2
3	MENACHEM SHABAT	OWNER	Administrative	10.64	SEE ATTACHED			SALARY	28,000	17-3	3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 256,000		13

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

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

Facility Name & ID Number PETERSON PARK HC CTR # 0024463 Report Period Beginning: 01/01/2012 Ending: 2/31/2012

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number PETERSON PARK HC CTR # 0024463 Report Period Beginning: 01/01/2012 Ending: 2/31/2012

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization: LEGACY HEALTHCARE FINANCIAL SVCS
Street Address: 7040 RIDGEWAY
City / State / Zip Code: LINCOLNWOOD ILL 60712
Phone Number: (847) 679-9797
Fax Number: (847) 679-3676

	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	2	FOOD	Bed Days Available	716,018	13	$ 270	$	68,808	$ 26	1
2	3	HOUSEKEEPING	Bed Days Available	716,018	13	12,097		68,808	1,162	2
3	5	UTILITIES	Bed Days Available	716,018	13	17,526		68,808	1,684	3
4	6	GROUNDS & MAINTENANCE	Bed Days Available	716,018	13	28,596		68,808	2,748	4
5	17	MANAGEMENT FEES	WEIGHTED AVERAGE	100	12	400,000	400,000	14	56,000	5
6	19	PROFESSIONAL FEES	Bed Days Available	716,018	13	67,029		68,808	6,441	6
7	20	FEES,SUBSCRIPTIONS	Bed Days Available	716,018	13	625		68,808	60	7
8	21	CLERICAL & GENERAL	Bed Days Available	716,018	13	1,563,793		68,808	150,278	8
9	24	SEMINARS	Bed Days Available	716,018	13	2,200		68,808	211	9
10	26	INSURANCE	Bed Days Available	716,018	13	7,687		68,808	739	10
11	27	EMPL BENEFITS-GEN ADMIN	Bed Days Available	716,018	13	228,907		68,808	21,998	11
12	27	EMPL BENEFITS-OWNERS	WEIGHTED AVERAGE	100	13	113,000		14	15,820	12
13	30	DEPRECIATION	Bed Days Available	716,018	13	12,480		68,808	1,199	13
14	32	INTEREST	Bed Days Available	716,018	13	51		68,808	5	14
15	34	RENT	Bed Days Available	716,018	13	133,442		68,808	12,824	15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 2,587,703	$ 400,000		$ 271,195	25

Facility Name & ID Number PETERSON PARK HC CTR # 0024463 Report Period Beginning: 01/01/2012 Ending: 2/31/2012

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization: LEGACY REAL PROPERTIES LLC
Street Address: 7040 RIDGEWAY
City / State / Zip Code: LINCOLNWOOD ILL 60712
Phone Number: (847) 679-9797
Fax Number: (847) 679-3676

	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	30	DEPRECIATION	Bed Days Available	716,018	13	$ 25,098	$	68,808	$ 2,412	1
2	32	INTEREST EXPENSE	Bed Days Available	716,018	13	45,486		68,808	4,371	2
3	33	REAL ESTATE TAXES	Bed Days Available	716,018	13	44,250		68,808	4,252	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					$ 114,834	$		$ 11,035	25

Facility Name & ID Number PETERSON PARK HC CTR # 0024463 Report Period Beginning: 01/01/2012 Ending: 2/31/2012

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: Progressive Healthcare Consulting
Street Address: 7040 RIDGEWAY
City / State / Zip Code: LINCOLNWOOD ILL 60712
Phone Number: (847) 679-9797
Fax Number: (847) 679-3676

	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	10	RN SALARIES	Bed Days Available	498,858	9	$ 88,262	$ 88,262	68,808	$ 12,174	1
2	12	CLERGY SALARY	Bed Days Available	498,858	9	18,263	18,263	68,808	2,519	2
3	15	EMPLOYEE BENEFITS	Bed Days Available	498,858	9	11,955		68,808	1,649	3
4	17	ADMIN	Bed Days Available	498,858	9	186,212		68,808	25,684	4
5	19	PROFESSIONAL FEES	Bed Days Available	498,858	9	1,215		68,808	168	5
6	21	CLERICAL AND GENERAL	Bed Days Available	498,858	9	2,058		68,808	284	6
7	35	AUTO RENTAL	Bed Days Available	498,858	9	999		68,808	138	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					$ 308,964	$ 106,525		$ 42,616	25

Facility Name & ID Number PETERSON PARK HC CTR # 0024463 Report Period Beginning: 01/01/2012 Ending: 2/31/2012

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization: SHABAT & ACCOCIATES
Street Address: 7040 RIDGEWAY
City / State / Zip Code: LINCOLNWOOD ILL 60712
Phone Number: (847) 679-9797
Fax Number: (847) 679-3676

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	SALARY- RON SHABAT	DIRECT	1	1	$ 95,714	$ 95,714	1	$ 95,714	1
2	27	PAYROLL TAXES	DIRECT	1	1	1,388		1	1,388	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					$ 97,102	$ 95,714		$ 97,102	25

Facility Name & ID Number PETERSON PARK HC CTR # 0024463 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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	RELATED PARTY: PETERSON PARK REALTY						$	$			$	1
2	HEARTLAND BANK		X	MORTGAGE	$39,040.00	10/16/04	6,296,100			0.0560	327,047	2
3	BEECH STREET		X	MORTGAGE	$33,404.55	07/01/12	5,545,100	5,460,183	11/01/29	0.0265	60,758	3
4	LOAN COSTS		X	write off old mort costs							111,770	4
5	LOAN COSTS		X	AMORTIZE OVER LIFE OF LOAN							3,571	5
	Working Capital											
6	BANK FINANCIAL		X	LINE OF CREDIT							49,169	6
7											265	7
8	RELATED PARTY										4,376	8
9	TOTAL Facility Related				$72,444.55		$ 11,841,200	$ 5,460,183			$ 556,956	9
	B. Non-Facility Related*											
10	IRS, IDR, ETC		X	LATE FEES								10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 11,841,200	$ 5,460,183			$ 556,956	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ 24,482 Line # 36

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number PETERSON PARK HC CTR # 0024463 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2011 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 230,635	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.)		$ 233,727	2
3. Under or (over) accrual (line 2 minus line 1).		$ 3,092	3
4. Real Estate Tax accrual used for 2012 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 229,676	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.)**		$ 11,377	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 $ 33,864 For 2009 Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$ (33,864)	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 210,281	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2007	215,745	8
	2008	214,298	9
	2009	221,013	10
	2010	230,635	11
	2011	233,727	12

THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED ON ~ 100% OF THE PRIOR YEAR REAL ESTATE TAX BILL

THE PAYMENT ON LINE 2 APPLIES TO THE 2011 TAX BILL.

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2011	$	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.

2011 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME PETERSON PARK HC CTR COUNTY COOK

FACILITY IDPH LICENSE NUMBER 0024463

CONTACT PERSON REGARDING THIS REPORT BOB KAGDA

TELEPHONE (847) 675-3585 FAX #: (847) 675-5777

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

Enter the tax index number and real estate tax assessed for 2011 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 2011.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	13-02-115-052-0000	NURSING HOME	$ 229,675.57	$ 229,675.57
2.			$	$
3.	10-35-104-076-0000	HOME OFFICE ALLOCATION	$ 42,154.05	$ 4,050.93
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 271,829.62	$ 233,726.50

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 2011 tax bills which were listed in Section A to this statement. Be sure to use the 2011 tax bill which is normally paid during 2012.

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

Facility Name & ID Number PETERSON PARK HC CTR # 0024463 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

X. BUILDING AND GENERAL INFORMATION:

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

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

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

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

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

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

N/A

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

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

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

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

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	FACILITY		1986	$ 283,071	1
2	ALLOC FR LEGACY RP			7,862	2
3	TOTALS			$ 290,933	3

Facility Name & ID Number PETERSON PARK HC CTR # 0024463 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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	188		1986		$ 2,548,850	$ 131,570	35	$ 72,824	$ (58,746)	$ 1,966,248	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	VARIOUS			1979	4,800					4,800	9
10	VARIOUS			1981	57,728					57,728	10
11	VARIOUS			1982	11,967					11,967	11
12	VARIOUS			1983	3,440					3,440	12
13	VARIOUS			1984	12,700					12,700	13
14	VARIOUS			1985	98,707					98,707	14
15	VARIOUS			1986	42,087		31			42,087	15
16	VARIOUS			1987	17,729		31	572	572	14,734	16
17	VARIOUS			1988	35,577		31	1,147	1,147	27,909	17
18	VARIOUS			1989	14,591		31	470	470	10,999	18
19	VARIOUS			1990	27,693		31	894	894	20,013	19
20	VARIOUS			1991	62,352		20			62,352	20
21	VARIOUS			1992	10,152		20			10,152	21
22	VARIOUS			1993	21,815		20	1,092	1,092	21,407	22
23	VARIOUS			1994	264,384		20	13,226	13,226	241,454	23
24	VARIOUS			1995	103,507		20	5,176	5,176	90,339	24
25	VARIOUS			1996	35,086		20	1,757	1,757	29,094	25
26	VARIOUS			1997	62,950		20	3,150	3,150	48,500	26
27	VARIOUS			1998	49,698		20	2,487	2,487	36,598	27
28	VARIOUS			1999	87,532		20	4,383	4,383	60,562	28
29	VARIOUS			2000	188,443		20	9,427	9,427	118,065	29
30	VARIOUS			2001	73,918		20	3,700	3,700	43,182	30
31	VARIOUS			2002	350,099		20	17,508	17,508	183,820	31
32	VARIOUS			2003	78,238		20	3,908	3,908	37,150	32
33	VARIOUS			2004	66,172		20	3,309	3,309	28,103	33
34	VARIOUS			2005	53,841		20	2,693	2,693	19,880	34
35	VARIOUS			2006	50,608		20	2,531	2,531	16,443	35
36											36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number PETERSON PARK HC CTR # 0024463 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 4,434,664	$ 131,570		$ 150,254	$ 18,684	$ 3,318,433	70

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

Facility Name & ID Number PETERSON PARK HC CTR # 0024463 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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		$ 4,434,664	$ 131,570		$ 150,254	$ 18,684	$ 3,318,433	1
2	CONCRETE DOCK	2007	3,500		15	233	233	1,272	2
3	REHAB NURSING STATION	2007	11,394		20	570	570	3,135	3
4	RENOVATION 1ST FLOOR CORRIDOR AND LOBBY	2007	255,996		20	12,800	12,800	70,400	4
5	RENOVATION THERAPY REHAB ROOM	2007	12,744		20	637	637	3,504	5
6	SECURITY SYSTEM	2007	6,100		20	305	305	1,677	6
7	ROOF	2007	17,600		20	880	880	2,860	7
8	5 TON MULGIAGUA R-22 PACKGD ELECTRIC HIGH EFF	2007	32,940		20	1,647	1,647	9,059	8
9	CABLE WIRING	2007	12,500		20	625	625	3,437	9
10	NURSE CALL SYSTEM	2007	10,612		20	531	531	2,920	10
11	CIRCULATION OF HOT WATER LINES	2007	8,770		20	439	439	2,414	11
12	REAR ENTRANCE DOOR	2007	3,308		20	165	165	908	12
13	ELEVATOR REHAB 4 NEW NYLON PLATED GUILDE SHOES	2007	3,297		20	165	165	908	13
14	LANDSCAPING	2008	16,600		15	1,107	1,107	4,982	14
15	AWNING	2008	3,500		27.5	127	127	596	15
16	ELEVATOR REHAB	2008	5,500		27.5	200	200	938	16
17	ROOF	2008	4,000		27.5	145	145	680	17
18	COOPER PIPING	2008	2,860		27.5	104	104	488	18
19	CABLE WIRING	2008	3,850		27.5	140	140	656	19
20	A/C UNITS	2008	4,497		27.5	163	163	764	20
21	GATE VALVES	2008	2,800		27.5	102	102	478	21
22	NURSE CALL SYSTEM	2008	11,990		27.5	436	436	2,044	22
23	REPLACE HOT WATER & CIRCULATION LINES	2008	3,900		27.5	142	142	666	23
24	CABLE WIRING	2008	10,460		27.5	380	380	1,782	24
25	HOT WATER LINES	2008	7,500		27.5	273	273	1,280	25
26	A/C UNITS WITH SLEEVES	2008	3,951		27.5	144	144	675	26
27	BUILD IN WARDROBE CABINETS	2008	20,641		27.5	751	751	3,520	27
28	PAINTING	2009	39,906		20	1,995	1,995	9,976	28
29	SHADES, CORNICES & PANELS	2009	51,425		20	2,571	2,571	12,856	29
30	FLOORING & CARPETING	2009	5,410		20	271	271	1,354	30
31	WALLCOVERING, CORNICES & PANELS	2009	10,770		20	539	539	2,694	31
32	VINYL FLOORING	2009	5,481		20	274	274	1,370	32
33	SMOKE DETECTORS	2009	7,000		27.5	255	255	839	33
34	TOTAL (lines 1 thru 33)		$ 5,035,466	$ 131,570		$ 179,370	$ 47,800	$ 3,469,565	34

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

Facility Name & ID Number PETERSON PARK HC CTR # 0024463 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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		$ 5,035,466	$ 131,570		$ 179,370	$ 47,800	$ 3,469,565	1
2	GREASE TRAPS	2009	2,790		27.5	101	101	333	2
3	RECONDITION BOILER	2009	6,405		27.5	233	233	767	3
4	HOT WATER LINE	2009	5,180		27.5	188	188	619	4
5	WATER HEATER	2009	3,650		27.5	133	133	438	5
6	NURSE CALL SYSTEM	2009	21,666		27.5	788	788	2,594	6
7	HOT WATER & CIRCULATION LINE	2009	5,420		27.5	197	197	648	7
8	HOW WATER & CIRCULATION PIPES	2009	4,760		27.5	173	173	569	8
9	DRYWALL	2009	2,500		27.5	91	91	300	9
10	COPPER PIPING	2009	5,700		27.5	207	207	681	10
11	BATHROOM REMOD - LAVATORY, LIGHT FIX, WALL TOW	2009	12,407		27.5	451	451	1,485	11
12	CHAIR RAIL	2009	4,329		27.5	157	157	517	12
13	DRYWALL & DRAINS FOR 2 BATHTUBS	2009	5,600		27.5	204	204	671	13
14	PATIO	2009	10,390		15	693	693	2,339	14
15									15
16									16
17									17
18	DRYWALL METAL STUDS TIME & CONVERT TUB 2 SHOWI	2010	4,450		20	223	223	557	18
19	ROOM SIGNS	2010	12,108		20	605	605	1,513	19
20	CLINICAL SINKS	2010	7,121		20	356	356	890	20
21	PLUMBING IN UTILITY ROOM	2010	9,651		20	483	483	1,207	21
22	SIGN	2010	13,700		15	913	913	2,283	22
23	NURSES STATION - PANELS, BOARDS, GRANITE TOPS	2010	30,280		20	1,514	1,514	3,785	23
24	REHAB BATHROOM - ARCHITECT FEES	2010	4,170		20	209	209	522	24
25	REHAB BATHROOM - FAUCETS, LIGHTING, FLOORS	2010	32,452		20	1,623	1,623	4,057	25
26	CORRIDOR & DAY ROOM RENOV - COVE BASE, WINDOWS	2010	172,082		20	8,604	8,604	21,510	26
27	SOILDED UTILITY ROOM RENOVATION - CABINETS, SINK	2010	23,598		20	1,180	1,180	2,950	27
28	REHAB BATHROOMS - WALLS, LIGHTING, FLOORS	2010	77,780		20	3,889	3,889	9,723	28
29	CORRIDOR RENOVATION - WALLS, CHAIR RAILS, FLOORS	2010	172,732		20	8,637	8,637	21,592	29
30	TILING & WALLCOVERING FOR FOYER	2010	3,549		20	177	177	443	30
31	GENERATOR REPAIR	2010	2,526		20	126	126	315	31
32	THRU THE WALL HEATING & A/C UNITS	2010	5,626		20	281	281	703	32
33	SINKS & FAUCETS	2010	3,270		20	164	164	410	33
34	TOTAL (lines 1 thru 33)		$ 5,701,358	$ 131,570		$ 211,970	$ 80,400	$ 3,553,986	34

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

Facility Name & ID Number PETERSON PARK HC CTR # 0024463 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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		$ 5,701,358	$ 131,570		$ 211,970	$ 80,400	$ 3,553,986	1
2	TILING, PAINTING & REMODEL SOCIAL ROOM HALL OFF	2010	15,730		20	787	787	1,967	2
3	DRYWALL	2010	3,920		20	196	196	490	3
4	CHANGE LOCKS	2010	4,481		20	224	224	560	4
5	REMODEL PUBLIC BATHROOMS FLOOR WALL TOILET LI	2010	7,503		20	375	375	938	5
6	SHUT OFF VALVE & ACCESS PANELS IN SOILED UTLY RM	2010	3,994		20	200	200	500	6
7	REPLACE DRYWALL & STUDS IN BATHROOM	2010	2,930		20	147	147	367	7
8	REPLACE EXISTING TILE & BASEBOARDS & PAINT WALL	2010	9,990		20	499	499	1,248	8
9	REPLACE DRYWALL & STUDS & PAINTING	2010	7,918		20	396	396	990	9
10	REBUILT EJECTOR PUMP	2010	5,400		20	270	270	675	10
11	BATHROOM RESTORATION - WALLS & DRAINS	2010	9,350		20	468	468	1,170	11
12	RADIATOR HEATING SYSTEM	2010	9,590		20	480	480	1,200	12
13	HANDRAILS, BUMPERS, DOOR KNOBS	2010	4,350		20	218	218	545	13
14	TILING & BASEBOARDS, WALLS, CEILINGS, PAINT	2010	12,995		20	650	650	1,625	14
15	KITCHEN & EXHAUST FAN DUCTS, ELECTRICIAL	2010	3,522		20	176	176	440	15
16	PAINTING & SINK IN MED ROOM	2010	6,470		20	324	324	810	16
17	DRYWALL, TILING, RAISING NURSE CALL SWITCHES	2010	4,050		20	203	203	507	17
18	PUMP REPAIRS/PUMP SEAL KIT	2010	2,642		20	132	132	330	18
19	ROOF - DRAINAGE	2010	2,600		20	130	130	325	19
20	DRAIN WATER LINE	2010	2,800		20	140	140	650	20
21	GLASS WALL/DOOR	2010	14,800		20	740	740	1,850	21
22	EMERGENCY/EXIT DOORS/DOOR OPENER	2010	4,200		20	210	210	525	22
23	ELECTRIAL & LIGHTING	2010	7,720		20	386	386	965	23
24	SIX WINDOWS	2010	3,000		20	150	150	375	24
25	HOT WATER TANK	2010	14,680		20	734	734	1,835	25
26	BEAUTY MIRROR INSTALLATION	2010	2,500		20	125	125	313	26
27									27
28	ARCHITECT FEES	2011	6,000		27.5	173	173	346	28
29	CUSTOM CABINETS BUILD IT SECURED TO WALL	2011	2,800		27.5	81	81	162	29
30	SEWER PUMP MOTOR	2011	2,910		27.5	84	84	168	30
31	ARCHITECT FEES	2011	6,474		27.5	186	186	372	31
32	BOILERS	2011	63,550		27.5	1,829	1,829	3,658	32
33	DOORS WINDOWS & THERMOBRAKE METAL	2011	16,100		27.5	317	317	634	33
34	TOTAL (lines 1 thru 33)		$ 5,966,327	$ 131,570		$ 223,000	$ 91,430	$ 3,580,526	34

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

Facility Name & ID Number PETERSON PARK HC CTR # 0024463 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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		$ 5,966,327	$ 131,570		$ 223,000	$ 91,430	$ 3,580,526	1
2	MILLWORK & TRIM	2011	2,600		27.5	27	27	54	2
3	ELECTRIAL WORK IN BOILER/ELECTRICAL ROOM	2011	7,800		27.5	83	83	166	3
4	SPRINKLER SYSTEM CONNECTION	2011	3,900		27.5	41	41	82	4
5	INSTALL 2 NEW DEDICATED CIRCUITS NEW WASH/DRYR	2011	2,800		27.5	30	30	60	5
6	HIGH EFFICENCY CONDENSER	2011	4,250		27.5	45	45	90	6
7	REPLACE KITCHEN TILE	2011	4,230		27.5	19	19	38	7
8	REPLACE KITCHEN TILE	2011	3,865		27.5	18	18	36	8
9	HOT WATER BOILER REPAIRS IN BASEMENT	2011	7,250		27.5	33	33	66	9
10	DRAIN LINE REPLACEMENT	2011	2,700		27.5	12	12	24	10
11	SECURITY KEYPAD & WIRING FOR ELEVATOR	2011	5,950		27.5	27	27	54	11
12	REPLACE KITCHEN TILE	2011	3,975		27.5	18	18	36	12
13	CONCRETE WORK	2011	19,140		15	638	638	1,276	13
14	CANOPYS	2011	14,890		15	497	497	994	14
15	LANDSCAPE IRRIGATION SYSTEM	2011	11,880		15	396	396	792	15
16	PLANT INSTALLATION	2011	19,030		15	635	635	1,270	16
17	CORNICES, BLINDS, SHEERS	2011	10,058		5	1,006	1,006	2,012	17
18	EJECTOR PUMP	2012	7,190		27.5	76	76	76	18
19	LOCKERS	2012	4,058		27.5	43	43	43	19
20	ELECTRICAL CIRCUIT	2012	3,225		27.5	34	34	34	20
21	exterior fire doors on both sides of building first floor, and								21
22	doors on the laundry shoot-first and second floor	2012	5,720		27.5	61	61	61	22
23	FIRE SPRINKLER	2012	3,990		27.5	42	42	42	23
24	window sill replacement on all windows on 1st & 2nd floor	2012	6,104		27.5	65	65	65	24
25	REPLACE METAL STUDS & DRYWALL IN STORAGE ROOM	2012	2,630		27.5	28	28	28	25
26	ELECTRIC WORK IN KITCHEN AREA	2012	2,970		27.5	31	31	31	26
27	REPLACED CRACKED DRAIN LINE	2012	2,580		27.5	27	27	27	27
28	HOT WATER BOILER	2012	84,380		27.5	895	895	895	28
29	REPLACED FASCIA GUTTERS,GRAVEL STOPPERS & ROOI	2012	17,900		27.5	190	190	190	29
30	TILE, NEW BASE LINER & CONCRETE BASE IN SHOWER	2012	6,320		27.5	67	67	67	30
31	NEW FIRE PANEL	2012	21,600		27.5	229	229	229	31
32	SCALD GUARD FOR SHOWERS	2012	6,663		27.5	71	71	71	32
33	ROOF-PATCH OPEN SEAMS, DRAINS AND FLESHING	2012	5,140		27.5	55	55	55	33
34	TOTAL (lines 1 thru 33)		$ 6,271,115	$ 131,570		$ 228,439	$ 96,869	$ 3,589,490	34

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

Facility Name & ID Number PETERSON PARK HC CTR # 0024463 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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 12E, Carried Forward		$ 6,271,115	$ 131,570		$ 228,439	$ 96,869	$ 3,589,490	1
2	shower remodeling-new base liner,concrete base,tile install	2012	3,980		27.5	42	42	42	2
3	ELECTRIC WORK IN BOILER ROOM	2012	4,130		27.5	44	44	44	3
4	WALK IN FREEZER	2012	4,636		27.5	49	49	49	4
5	COMPRESSOR	2012	2,800		27.5	30	30	30	5
6	HORIZONTAL RAILING BARS FOR STAIRWAYS	2012	6,900		27.5	73	73	73	6
7	BOILER EXHAUST LINES	2012	7,200		27.5	76	76	76	7
8	GREASE TRAP	2012	4,200		27.5	45	45	45	8
9	TV OUTLETS	2012	11,445		27.5	121	121	121	9
10	DRYWALL, PATCH & SAND	2012	2,986		27.5	32	32	32	10
11	NEW PARKING LOT	2012	24,390		15	813	813	813	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)		$ 6,343,782	$ 131,570		$ 229,764	$ 98,194	$ 3,590,815	34

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

Facility Name & ID Number PETERSON PARK HC CTR # 0024463 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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 12F, Carried Forward		$ 6,343,782	$ 131,570		$ 229,764	$ 98,194	$ 3,590,815	1
2									2
3									3
4	RELATED PARTY INFORMATION								4
5	BUILDINGS:								5
6	ALLOCATED FROM LEGACY RP	2009	60,913		30	1,130	1,130		6
7									7
8									8
9									9
10	LEASEDHOLD IMPROVEMENTS:								10
11	ALLOCATED FROM LEGACY RP	2009	34,592		20	279	279		11
12	ALLOCATED FROM LEGACY RP	2010	10,519		20	85	85		12
13	ALLOCATED FROM LEGACY RP	2011	14,951		20	121	121		13
14									14
15									15
16									16
17									17
18									18
19									19
20	ALLOCATED FROM LEGACY HEALTHCARE FINANCIAL	2012	2,740		20	209	209		20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 6,467,497	$ 131,570		$ 231,588	$ 100,018	$ 3,590,815	34

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

Facility Name & ID Number PETERSON PARK HC CTR # 0024463 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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	$ 435,735	$	$ 43,571	$ 43,571	10 yrs	$ 180,667	71
72	Current Year Purchases							72
73	Fully Depreciated Assets	1,169,943					1,169,943	73
74	RELATED PARTY		43,156	43,156				74
75	TOTALS	$ 1,605,678	$ 43,156	$ 86,727	$ 43,571		$ 1,350,610	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				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 8,364,108	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 174,726	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 318,315	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 143,589	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 4,941,425	85	

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

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

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

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

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

Facility Name & ID Number PETERSON PARK HC CTR # 0024463 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

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

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$ 1,054,741			3
4	Additions							4
5								5
6								6
7	TOTAL				$ 1,054,741 **			7

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

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
    Beginning
    Ending

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

	Fiscal Year Ending	Annual Rent
12.	/2013	$
13.	/2014	$
14.	/2015	$

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: $ 15,007 Description: SEE SCHEDULE ATTACHED
    (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	SEE ATTACHED		$	$ 10,651	17
18					18
19					19
20					20
21	TOTAL		$	$ 10,651	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 PETERSON PARK HC CTR # 0024463 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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.

   THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES

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.

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

	Service	1 Schedule V Line & Column Reference	2 Staff Units of Service	3 Staff Cost	4 Outside Practitioner (other than consultant) Units	5 Outside Practitioner (other than consultant) Cost	6 Supplies (Actual or) Allocated)	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39-3	hrs	$		$ 305,707	$		$ 305,707	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			172,295			172,295	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			294,468			294,468	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescrpts				290,217		290,217	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): Radiology					11,886			11,886	13
14	TOTAL			$		$ 784,356	$ 290,217		$ 1,074,573	14

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

Facility Name & ID Number PETERSON PARK HC CTR # 0024463 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2012 (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	$ 811,328	$ 862,382	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (566,941))	2,027,336	2,027,336	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	55,530	261,081	6
7	Other Prepaid Expenses		408,803	7
8	Accounts Receivable (owners or related parties)	59,166	59,166	8
9	Other(specify): medicare co ins pass thru	118,895	118,895	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 3,072,255	$ 3,737,663	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		102,484	13
14	Buildings, at Historical Cost		2,548,850	14
15	Leasehold Improvements, at Historical Cost		3,467,414	15
16	Equipment, at Historical Cost		1,871,383	16
17	Accumulated Depreciation (book methods)		(5,294,791)	17
18	Deferred Charges		119,643	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): due from pprealty,partners	3,076,693	3,076,693	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 3,076,693	$ 5,891,676	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 6,148,948	$ 9,629,339	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 481,036	$ 486,136	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	3,980	3,980	28
29	Short-Term Notes Payable		259,294	29
30	Accrued Salaries Payable	704,206	704,206	30
31	Accrued Taxes Payable (excluding real estate taxes)	76,747	76,747	31
32	Accrued Real Estate Taxes(Sch.IX-B)		229,676	32
33	Accrued Interest Payable		12,058	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	ACCRUED MANAGEMENT FEES	107,767	107,767	36
37	BED TAX			37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,373,736	$ 1,879,864	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		5,200,889	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	due to peterson park operations		2,544,146	43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$ 7,745,035	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,373,736	$ 9,624,899	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 4,775,212	$ 4,440	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 6,148,948	$ 9,629,339	48

***(See instructions.)**

Facility Name & ID Number PETERSON PARK HC CTR # 0024463 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total		
1	**Balance at Beginning of Year, as Previously Reported**	$ 3,818,739	1	
2	Restatements (describe):		2	
3	POST CLOSING ADJ	576,228	3	
4			4	
5			5	
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 4,394,967	6	
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	680,245	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	(300,000)	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)**	$ 380,245	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)**	$ 4,775,212	24	*

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

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XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 13,468,303	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 13,468,303	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	6,445	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 6,445	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 13,474,748	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,766,818	31
32	Health Care	3,845,922	32
33	General Administration	4,337,983	33
	B. Capital Expense		
34	Ownership	1,137,920	34
	C. Ancillary Expense		
35	Special Cost Centers	1,074,573	35
36	Provider Participation Fee	616,637	36
	D. Other Expenses (specify):		
37			37
38	OTHER EXPENSE ADJUSTMENTS	14,650	38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 12,794,503	40
41	**Income before Income Taxes (line 30 minus line 40)****	680,245	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 680,245	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 8,148,565	44
45	Private Pay - Net Inpatient Revenue	941,346	45
46	Medicare - Net Inpatient Revenue	4,257,193	46
47	Other-(specify) VETERAN	106,509	47
48	Other-(specify) INSURANCE	14,690	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 13,468,303	49

****TAX RETURN PREPARED ON CASH BASIS**

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

** **Does this agree with taxable income (loss) per Federal Income Tax Return? NO** If not, please attach a reconciliation.**

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

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

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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	1,994	2,551	$ 143,128	$ 56.11	1
2	Assistant Director of Nursing	1,878	2,091	81,737	39.09	2
3	Registered Nurses	39,491	44,713	1,330,987	29.77	3
4	Licensed Practical Nurses	3,665	4,099	94,371	23.02	4
5	CNAs & Orderlies	94,615	101,708	1,113,577	10.95	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	8,477	9,646	174,414	18.08	8
9	Activity Director	1,798	2,062	28,218	13.68	9
10	Activity Assistants	11,453	12,838	142,680	11.11	10
11	Social Service Workers	10,009	10,879	176,162	16.19	11
12	Dietician					12
13	Food Service Supervisor	114	126	1,599	12.69	13
14	Head Cook					14
15	Cook Helpers/Assistants	23,495	25,866	328,221	12.69	15
16	Dishwashers					16
17	Maintenance Workers	3,904	4,272	66,401	15.54	17
18	Housekeepers	17,638	19,351	199,254	10.30	18
19	Laundry	10,325	11,454	143,508	12.53	19
20	Administrator	3,746	4,073	202,495	49.72	20
21	Assistant Administrator	1,254	1,470	48,474	32.98	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	16,714	18,433	258,515	14.02	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	1,489	1,660	39,721	23.93	31
32	Other Health Care(specify)	6,306	7,030	142,816	20.32	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	258,365	284,322	$ 4,716,278 *	$ 16.59	34

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	MONTHLY	$ 10,389	1-3	35
36	Medical Director	MONTHLY	6,000	9-3	36
37	Medical Records Consultant	QUARTERLY	1,568	10-3	37
38	Nurse Consultant		0	10-3	38
39	Pharmacist Consultant	MONTHLY	10,998	10-3	39
40	Physical Therapy Consultant		0	10a-3	40
41	Occupational Therapy Consultant		0	10a-3	41
42	Respiratory Therapy Consultant		0	10a-3	42
43	Speech Therapy Consultant		0	10a-3	43
44	Activity Consultant	MONTHLY	5,940	11-3	44
45	Social Service Consultant	MONTHLY	7,312	12-3	45
46	Other(specify) Nursing Consultant	MONTHLY	24,000	10-3	46
47	Nursing Program Consultant	MONTHLY	45,000	10-3	47
48					48
49	TOTAL (lines 35 - 48)		$ 111,207		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$ 0	10-3	50
51	Licensed Practical Nurses		0	10-3	51
52	Certified Nurse Assistants/Aides		0	10-3	52
53	TOTAL (lines 50 - 52)		$		53

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
ALICIA OSHINSKI	ADMINISTRATOR	0	$ 98,209
IGOR SHNEYDERMAN	ASST ADMIN	0	48,474
RONALD SHABAT	ADMINISTRATIVE	69.15	104,286
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 250,969

B. Administrative - Other

Description	Amount
SHABAT & ASSOCIATES	$ 1,482,588
LEGACY HEALTHCARE	457,565
TOTAL (agree to Schedule V, line 17, col. 3)	$ 1,940,153
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
		$
SEE SCHEDULE ATTACHED		144,551
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$ 144,551

D. Employee Benefits and Payroll Taxes

Description		Amount
Workers' Compensation Insurance		$ 210,486
Unemployment Compensation Insurance		22,809
FICA Taxes		353,548
Employee Health Insurance		248,337
Employee Meals		65,002
Illinois Municipal Retirement Fund (IMRF)*		
EMPLOYEE BENEFITS - OTHER		36,095
EMPLOYEE PHYSICAL EXAMS		333
PENSION/PROFIT SHARING PLANS		45,544
CHICAGO HEAD TAX		4,092
INSURANCE - EXECUTIVE LIFE		2,671
PAYROLL TAXES - LEGACY		4,224
INSURANCE - EXECUTIVE LIFE	VI 21	(2,671)
TOTAL (agree to Schedule V, line 22, col.8)		$ 990,470

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	0
Health Care Worker Background Check	2,290
(Indicate # of checks performed 229)	
Patient Background Checks 26	517
TRUST/FRANCHISE/CONTRIB/ETC	76,028
MARKETING/ADV/PROMO	41,827
LICENSES/DUES/SUBSCRIPTIONS	12,631
REL PARTY ALLOC	310
TRUST/FRANCHISE/CONTRIB/ETC	(76,028)
Less: Public Relations Expense	(0)
Non-allowable advertising	(41,827)
Yellow page advertising	(0)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 15,748

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
	0
Seminar Expense	
	0
rel party- seminars	211
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 211

* Attach copy of IMRF notifications

**See instructions.

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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			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

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XX. GENERAL INFORMATION:

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

(2) Are there any dues to nursing home associations included on the cost report? **YES**
If YES, give association name and amount. **ICLTC = $8,681**

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

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **NO** If YES, what is the capacity?

(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 YR**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **9,358** Line **10-2**

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

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

(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 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. $ **616,637**
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. $ **65,002** Has any meal income been offset against related costs? **N/A** Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **NO** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **5%**
d. Have vehicle usage logs been maintained? **NO**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **NO**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **YES**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **NO**
Firm Name:

(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.