		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.

2018
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2018)

I. IDPH License ID Number: 0024463

Facility Name: Peterson Park Hc Ctr

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

County: Cook

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

HFS ID Number:

Date of Initial License for Current Owners: 1/1/1978

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: Steven N. Lavenda **Telephone Number:** (847) 282-6300
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 01/01/18 to 12/31/18 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

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

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

Paid Preparer
(Signed)
** Subject to the attached Accountants' Consulting Report* (Date)
(Print Name and Title) Steven N. Lavenda, CPA, Partner
(Firm Name & Address) Marcum, LLP, 9 Parkway North, Suite 200 Deerfield, IL 60015
(Telephone) (847) 282-6300 Fax # (847) 282-6301

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: 01/01/18 Ending: 12/31/18

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 1/1/2018

	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)	196	71,540	1
2		Skilled Pediatric (SNF/PED)			2
3	95	Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	188	TOTALS	196	71,540	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	27,075	1,001	35,095	63,171	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	27,075	1,001	35,095	63,171	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 88.30%

D. How many bed reserve days during this year were paid by the Department?
None (Do not include bed reserve 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 1/1/1978

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 196 and days of care provided 3,007

Medicare Intermediary National Government Service

IV. ACCOUNTING BASIS

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

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

Tax Year: 12/31/2018 Fiscal Year: 12/31/2018

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

STATE OF ILLINOIS

Facility Name & ID Number Peterson Park Hc Ctr # 0024463 Report Period Beginning: 01/01/18 Ending: 12/31/18

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	585,907	39,823	5,910	631,640		631,640	1,262	632,902			1
2	Food Purchase		417,590		417,590		417,590	(9,821)	407,769			2
3	Housekeeping	259,833	49,550	701	310,084		310,084	1,985	312,069			3
4	Laundry	6,873	23,169	174,807	204,849		204,849	(5,265)	199,584			4
5	Heat and Other Utilities			198,633	198,633		198,633	(7,907)	190,726			5
6	Maintenance	100,039	24,177	154,920	279,136		279,136	8,899	288,035			6
7	Other (specify):*											7
8	**TOTAL General Services**	952,652	554,309	534,971	2,041,932		2,041,932	(10,847)	2,031,085			8
	B. Health Care and Programs											
9	Medical Director			30,816	30,816		30,816		30,816			9
10	Nursing and Medical Records	4,491,810	140,780	67,381	4,699,971		4,699,971	(13,706)	4,686,265			10
10a	Therapy	299,569			299,569		299,569		299,569			10a
11	Activities	225,553	12,596	4,371	242,520		242,520	79	242,599			11
12	Social Services	304,404	26,440	12,809	343,653		343,653	(21,526)	322,127			12
13	CNA Training											13
14	Program Transportation			20,316	20,316		20,316		20,316			14
15	Other (specify):*							9,051	9,051			15
16	**TOTAL Health Care and Programs**	5,321,336	179,816	135,693	5,636,845		5,636,845	(26,103)	5,610,742			16
	C. General Administration											
17	Administrative	112,013		660,000	772,013		772,013	(305,490)	466,523			17
18	Directors Fees											18
19	Professional Services			400,318	400,318	(5,505)	394,813	(269,828)	124,985			19
20	Dues, Fees, Subscriptions & Promotions			144,688	144,688		144,688	(110,416)	34,272			20
21	Clerical & General Office Expenses	359,449	8,120	442,056	809,625		809,625	(21,157)	788,468			21
22	Employee Benefits & Payroll Taxes			1,113,301	1,113,301		1,113,301	(38,486)	1,074,815			22
23	Inservice Training & Education											23
24	Travel and Seminar			4,494	4,494		4,494	3,462	7,956			24
25	Other Admin. Staff Transportation			594	594		594		594			25
26	Insurance-Prop.Liab.Malpractice			208,563	208,563		208,563	18,568	227,131			26
27	Other (specify):*							77,923	77,923			27
28	**TOTAL General Administration**	471,462	8,120	2,974,014	3,453,596	(5,505)	3,448,091	(645,423)	2,802,668			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	6,745,450	742,245	3,644,678	11,132,373	(5,505)	11,126,868	(682,373)	10,444,495			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 Number Peterson Park Hc Ctr #0024463 Report Period Beginning: 01/01/18 Ending: 12/31/18

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							548,163	548,163			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			55,882	55,882		55,882	75,379	131,261			32
33	Real Estate Taxes			(4)	(4)	5,505	5,501	354,714	360,215			33
34	Rent-Facility & Grounds			997,999	997,999		997,999	(997,817)	182			34
35	Rent-Equipment & Vehicles			6,870	6,870		6,870	4,724	11,594			35
36	Other (specify):*							19,657	19,657			36
37	**TOTAL Ownership**			1,060,747	1,060,747	5,505	1,066,252	4,820	1,071,072			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		377,610	763,289	1,140,899		1,140,899	(1,769)	1,139,130			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			469,272	469,272		469,272		469,272			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		377,610	1,232,561	1,610,171		1,610,171	(1,769)	1,608,402			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	6,745,450	1,119,855	5,937,986	13,803,291		13,803,291	(679,322)	13,123,969			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: 01/01/18 Ending: 12/31/18

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	(9,088)	05		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	319,037	30		9
10	Interest and Other Investment Income	(34,290)	32		10
11	Discounts, Allowances, Rebates & Refunds	(9,776)	02		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(66)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(1,042)	21		18
19	Entertainment	(2,660)	21		19
20	Contributions	(61,750)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(220,965)	21		24
25	Fund Raising, Advertising and Promotional	(35,214)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(15,935)	21		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(164,810)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (236,559)		$	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)	(442,763)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (442,763)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (679,322)		37

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

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

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

Peterson Park Hc Ctr

ID# 0024463

Report Period Beginning: 01/01/18

Ending: 12/31/18

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Miscellaneous Income	$ (6,998)	21	1
2	Contract Services - Sitter	(26,440)	12	2
3	Patient Personal Items	(37,464)	10	3
4	Bank Charges	(2,056)	21	4
5	Sequestration	(37,010)	21	5
6	Executive Life Insurance	(5,005)	22	6
7	Line of Credit	(3,525)	21	7
8	Collections	(44)	21	8
9	PAC Dues	(14,175)	20	9
10	Building Co - Amortization	(7,719)	36	10
11	Building Co - Professional Fees	(13,750)	19	11
12	Non-Allowable Legal	(8,855)	19	12
13	Pharmacy Discounts	(1,769)	39	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**	(164,810)		49

Peterson Park Hc Ctr

ID# 0024463

Report Period Beginning: 01/01/18

Ending: 12/31/18

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

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Peterson Park Hc Ctr # 0024463 Report Period Beginning: 01/01/18 Ending: 12/31/18

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary			1,262									1,262	1
2	Food Purchase	(9,842)		21									(9,821)	2
3	Housekeeping			1,985									1,985	3
4	Laundry			12						(5,277)			(5,265)	4
5	Heat and Other Utilities	(9,088)				1,181							(7,907)	5
6	Maintenance			9,911		1,589	(2,601)						8,899	6
7	Other (specify):*													7
8	**TOTAL General Services**	(18,930)		13,191		2,770	(2,601)			(5,277)			(10,847)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(37,464)		81,326	(57,309)				(259)				(13,706)	10
10a	Therapy													10a
11	Activities			79									79	11
12	Social Services	(26,440)		4,914									(21,526)	12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*				9,051								9,051	15
16	**TOTAL Health Care and Programs**	(63,904)		86,318	(48,258)				(259)				(26,103)	16
	C. General Administration													
17	Administrative			104,510							(410,000)		(305,490)	17
18	Directors Fees													18
19	Professional Services	(22,605)	13,750	(251,295)		49		(9,728)					(269,828)	19
20	Fees, Subscriptions & Promotions	(111,139)		723		1							(110,416)	20
21	Clerical & General Office Expenses	(290,236)		437,237	(168,547)	389							(21,157)	21
22	Employee Benefits & Payroll Taxes	(5,005)			(33,481)								(38,486)	22
23	Inservice Training & Education													23
24	Travel and Seminar			3,462									3,462	24
25	Other Admin. Staff Transportation													25
26	Insurance-Prop.Liab.Malpractice		12,230	5,882		455							18,568	26
27	Other (specify):*			66,227							11,696		77,923	27
28	**TOTAL General Administration**	(428,984)	25,980	366,747	(202,028)	894		(9,728)			(398,304)		(645,423)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(511,818)	25,980	466,256	(250,286)	3,664	(2,601)	(9,728)	(259)	(5,277)	(398,304)		(682,373)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Peterson Park Hc Ctr # 0024463 **Report Period Beginning:** 01/01/18 **Ending:** 12/31/18

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

	Capital Expense D. Ownership	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
30	Depreciation	319,037	229,126										548,163	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(34,290)	104,007	38		5,624							75,379	32
33	Real Estate Taxes		349,361			5,353							354,714	33
34	Rent-Facility & Grounds		(997,999)	48,811		(48,630)							(997,817)	34
35	Rent-Equipment & Vehicles				4,724								4,724	35
36	Other (specify):*	(7,719)	27,376										19,657	36
37	**TOTAL Ownership**	277,028	(288,129)	48,849	4,724	(37,653)							4,820	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers	(1,769)											(1,769)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*													43
44	**TOTAL Special Cost Centers**	(1,769)											(1,769)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(236,559)	(262,149)	515,106	(245,562)	(33,990)	(2,601)	(9,728)	(259)	(5,277)	(398,304)		(679,322)	45

Facility Name & ID Number Peterson Park Hc Ctr # 0024463 Report Period Beginning: 01/01/18 Ending: 12/31/18

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
See Page 6 Supplemental		See Page 6 Supplemental		See Page 6 Supplemental		

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	$ 997,999	Peterson Park Realty		$	$ (997,999)	1
2	V	32	Interest	207	Peterson Park Realty		104,214	104,007	2
3	V	36	Amortization Mortgage		Peterson Park Realty		7,719	7,719	3
4	V	30	Depreciation		Peterson Park Realty		229,126	229,126	4
5	V	26	Insurance		Peterson Park Realty		12,230	12,230	5
6	V	36	MIP Insurance		Peterson Park Realty		19,657	19,657	6
7	V	19	Professional Fees		Peterson Park Realty		13,750	13,750	7
8	V	33	RE Taxes		Peterson Park Realty		349,361	349,361	8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 998,206			$ 736,057	$ * (262,149)	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: 01/01/18 Ending: 12/31/18

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	01	DIETICIAN SALARY	$	Legacy Healthcare Financial Services		$ 1,189	$ 1,189	15
16	V	01	DIETARY SUPPLIES		Legacy Healthcare Financial Services		73	73	16
17	V	02	FOOD		Legacy Healthcare Financial Services		21	21	17
18	V	03	HOUSEKEEPING		Legacy Healthcare Financial Services		1,985	1,985	18
19	V	04	LINEN REPLACEMENT		Legacy Healthcare Financial Services		12	12	19
20	V	06	MAINTENANCE SALARY		Legacy Healthcare Financial Services		8,439	8,439	20
21	V	06	REPAIRS AND MAINTENANCE		Legacy Healthcare Financial Services		1,472	1,472	21
22	V	10	NURSING SALARY		Legacy Healthcare Financial Services		78,040	78,040	22
23	V	10	NURSE CONSULTANT		Legacy Healthcare Financial Services		3,196	3,196	23
24	V	10	MEDICAL SUPPLIES		Legacy Healthcare Financial Services		89	89	24
25	V	12	SOCIAL SERVICE SALARY		Legacy Healthcare Financial Services		4,885	4,885	25
26	V	11	ACTIVITIES PROGRAM		Legacy Healthcare Financial Services		79	79	26
27	V	12	SOCIAL SERVICE CONSULTANT		Legacy Healthcare Financial Services		29	29	27
28	V	17	CFO/ADMINISTRATIVE SALARY		Legacy Healthcare Financial Services		104,510	104,510	28
29	V	19	PROFESSIONAL FEES	264,000	Legacy Healthcare Financial Services		12,705	(251,295)	29
30	V	20	DUES/LICENSE/PERMITS		Legacy Healthcare Financial Services		723	723	30
31	V	21	CLERICAL AND GENERAL WAGES		Legacy Healthcare Financial Services		424,946	424,946	31
32	V	21	CLERICAL AND OFFICE EXPENSE		Legacy Healthcare Financial Services		12,291	12,291	32
33	V	24	EDUCATION AND SEMINARS		Legacy Healthcare Financial Services		3,462	3,462	33
34	V	26	INSURANCE- GENERAL		Legacy Healthcare Financial Services		5,882	5,882	34
35	V	27	NON-NURSING PAYROLL TAXES/BENEFITS		Legacy Healthcare Financial Services		66,227	66,227	35
36	V	32	INTEREST		Legacy Healthcare Financial Services		38	38	36
37	V	34	RENT		Legacy Healthcare Financial Services		48,630	48,630	37
38	V	34	OFFSITE STORAGE/PARKING		Legacy Healthcare Financial Services		181	181	38
39	Total			$ 264,000			$ 779,106	$ * 515,106	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: 01/01/18 Ending: 12/31/18

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	35	EQUIPMENT RENTAL		Legacy Healthcare Financial Services		253	$ 253	15
16	V	35	AUTO RENTAL		Legacy Healthcare Financial Services		4,471	4,471	16
17	V	15	NURSING PAYROLL TAXES/BENEFITS		Legacy Healthcare Financial Services		9,051	9,051	17
18	V	10	NURSE SALARY	57,309	Legacy Healthcare Financial Services			(57,309)	18
19	V	21	ADMINISTRATIVE SALARY	168,547	Legacy Healthcare Financial Services			(168,547)	19
20	V	22	PAYROLL TAXES	33,481	Legacy Healthcare Financial Services			(33,481)	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			$ 259,337			$ 13,775	$ * (245,562)	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: 01/01/18 Ending: 12/31/18

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	5	UTILITIES	$	CF St. Louis LLC		$ 1,181	$ 1,181	15
16	V	6	REPAIRS & MAINTENANCE		CF St. Louis LLC		1,589	1,589	16
17	V	19	PROFESSIONAL FEES		CF St. Louis LLC		49	49	17
18	V	20	DUES & SUBSCRIPTIONS		CF St. Louis LLC		1	1	18
19	V	21	OFFICE EXPENSE		CF St. Louis LLC		389	389	19
20	V	26	INSURANCE		CF St. Louis LLC		455	455	20
21	V	32	INTEREST EXPENSE		CF St. Louis LLC		5,624	5,624	21
22	V	33	REAL ESTATE TAXES		CF St. Louis LLC		5,353	5,353	22
23	V								23
24	V								24
25	V								25
26	V	34	RENT	48,630	CF St. Louis LLC			(48,630)	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			$ 48,630			$ 14,640	$ * (33,990)	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: 01/01/18 Ending: 12/31/18

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	06	Maintenance	$ 34,960	ML Group Design and Development		$ 32,359	$ (2,601)	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 34,960			$ 32,359	$ * (2,601)	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: 01/01/18 Ending: 12/31/18

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	19	Payroll Processing	$ 37,156	ProPay HR LLC		$ 27,428	$ (9,728)	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 37,156			$ 27,428	$ * (9,728)	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: 01/01/18 Ending: 12/31/18

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	Medical Supplies	$ 8,989	ReMED Services		$ 8,730	$ (259)	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 8,989			$ 8,730	$ * (259)	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: 01/01/18 Ending: 12/31/18

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	04	Laundry Services	$ 226,463	EcoBrite Linen		$ 221,186	$ (5,277)	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 226,463			$ 221,186	$ * (5,277)	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: 01/01/18 Ending: 12/31/18

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	17	Salary - Ron Shabat	$	Shabat & Associates		$ 250,000	$ 250,000	15
16	V	27	Payroll Taxes		Shabat & Associates		11,696	11,696	16
17	V	17	Management Fees	660,000	Shabat & Associates			(660,000)	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			$ 660,000			$ 261,696	$ * (398,304)	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: 01/01/18 Ending: 12/31/18

VII. RELATED PARTIES (continued)

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

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

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

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

Facility Name & ID Number Peterson Park Hc Ctr # 0024463 Report Period Beginning: 01/01/18 Ending: 12/31/18

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	Chaim Rajchenbach	5.32%	ASTORIA PLACE SKILLED NURSING FACILITY LLC	CHICAGO	PETERSON PARK REALTY	CHICAGO	BUILDING COMPANY	1
2	Menachem Shabat	9.04%	AVANTARA BILLINGS	BILLINGS, MT	LEGACY HC & FINANCIAL SERV	SKOKIE	HOME OFFICE/BOOKKEEPI	2
3	Jack Rajchenbach	9.57%	AVANTARA ELGIN	ELGIN	ML GROUP DESIGN & DEV	SKOKIE	ASSET MANAGEMENT	3
4	Ronald Shabat	69.15%	AVANTARA LONG GROVE	LONG GROVE	REMED SERVICES LLC	SKOKIE	NURSING EQUIPMENT	4
5	PPA, LTD.	5.32%	AVANTARA PARK RIDGE	PARK RIDGE	AURORA SUPPORTIVE LIVING	AURORA	SUPPORTIVE LIVING	5
6	Ahuva Shabat	1.60%	AZRIA MIDTOWN	OMAHA, NE	TERRACE GARDENS	MORTON GROVE	ASSISTED LIVING	6
7			AZRIA MONTCLAIR	OMAHA, NE	LINCOLNSHIRE ASSISTED LIVI	LINCOLNSHIRE	ASSISTED LIVING	7
8			AZRIA OLATHE	OLATHE, KS	CF ST. LOUIS LLC	SKOKIE	BUILDING COMPANY	8
9			BETHANY TERRACE	MORTON GROVE	PROPAY HR	EVANSTON	PAYROLL PROCESSING	9
10			CARLTON SKILLED NURSING FACILITY LLC	CHICAGO	ECOBRITE LINEN	SKOKIE	LAUNDRY SUPPLIES	10
11			CHALET SKILLED NURSING FACILITY LLC	CHICAGO	SHABAT & ASSOCIATES	SKOKIE	MANAGEMENT COMPANY	11
12			CLARK SKILLED NURSING FACILITY	CHICAGO				12
13			ELMBROOK SKILLED NURSING FACILITY LLC	ELMHURST				13
14			EVANSTON SKILLED NURSING FACILITY LLC	EVANSTON				14
15			GROVE AT THE LAKE SKILLED NURSING FACILITY LLC	ZION				15
16			GROVE OF FOX VALLEY	AURORA				16
17			GROVE OF ST. CHARLES	ST. CHARLES				17
18			LAGRANGE SKILLED NURSING FACILITY LLC	LAGRANGE PARK				18
19			LAKEFRONT SKILLED NURSING FACILITY LLC	CHICAGO				19
20			LINCOLN PARK SKILLED NURSING FACILITY LLC	CHICAGO				20
21			LINCOLNSHIRE LIVING & REHAB CENTER LLC	LINCOLNSHIRE				21
22			NORTHBROOK SKILLED NURSING FACILITY LLC	NORTHBROOK				22
23			SKOKIE SKILLED NURSING FACILITY LLC	SKOKIE				23
24			ST. GEORGE SKILLED NURSING FACILITY	ST. GEORGE, UT				24
25			VALLEY SKILLED NURSING FACILITY	BILLINGS, MT				25
26			WARREN BARR LIVING AND REHAB	CHICAGO				26
27			WARREN BARR NORTH SHORE	HIGHLAND PARK				27
28			WARREN BARR SOUTH LOOP	CHICAGO				28
29								29
30								30

Facility Name & ID Number Peterson Park Hc Ctr # 0024463 Report Period Beginning: 01/01/18 Ending: 12/31/18

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1								1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number Peterson Park Hc Ctr # 0024463 Report Period Beginning: 01/01/18 Ending: 12/31/18

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%	None	35	100.00%	Salary	$ 250,000	17-7	1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11	Where applicable, the amounts reported on this page have been adjusted from the actual costs to reflect only the amounts										11
12	anticipated to be considered allowable by the IL. Dept. of HFS.										12
13								TOTAL	$ 250,000		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: 01/01/18 Ending: 12/31/18

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number Peterson Park Hc Ctr # 0024463 Report Period Beginning: 01/01/18 Ending: 12/31/18

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization: Legacy Healthcare Financial Services
Street Address: 3450 Oakton Street
City / State / Zip Code: Skokie, IL 60076
Phone Number: (847) 679-9797
Fax Number: (847) 683-2900

	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	01	DIETICIAN SALARY	AVAIL. BED DAYS	1,918,919	34	$ 33,257	$ 33,257	68,620	$ 1,189	1
2	01	DIETARY SUPPLIES	AVAIL. BED DAYS	1,918,919	34	2,031		68,620	73	2
3	02	FOOD	AVAIL. BED DAYS	1,918,919	34	595		68,620	21	3
4	03	HOUSEKEEPING	AVAIL. BED DAYS	1,918,919	34	55,512		68,620	1,985	4
5	04	LINEN REPLACEMENT	AVAIL. BED DAYS	1,918,919	34	343		68,620	12	5
6	06	MAINTENANCE SALARY	AVAIL. BED DAYS	1,918,919	34	235,999	235,999	68,620	8,439	6
7	06	REPAIRS AND MAINTENANCE	AVAIL. BED DAYS	1,918,919	34	41,154		68,620	1,472	7
8	10	NURSING SALARY	AVAIL. BED DAYS	1,918,919	34	2,182,345	2,182,345	68,620	78,040	8
9	10	NURSE CONSULTANT	AVAIL. BED DAYS	1,918,919	34	89,384		68,620	3,196	9
10	10	MEDICAL SUPPLIES	AVAIL. BED DAYS	1,918,919	34	2,503		68,620	89	10
11	12	SOCIAL SERVICE SALARY	AVAIL. BED DAYS	1,918,919	34	136,611	136,611	68,620	4,885	11
12	11	ACTIVITIES PROGRAM	AVAIL. BED DAYS	1,918,919	34	2,204		68,620	79	12
13	12	SOCIAL SERVICE CONSULTAN	AVAIL. BED DAYS	1,918,919	34	800		68,620	29	13
14	17	CFO/ADMINISTRATIVE SALAR	AVAIL. BED DAYS	1,918,919	34	2,922,553	2,922,553	68,620	104,510	14
15	19	PROFESSIONAL FEES	AVAIL. BED DAYS	1,918,919	34	355,302		68,620	12,705	15
16	20	DUES/LICENSE/PERMITS	AVAIL. BED DAYS	1,918,919	34	20,207		68,620	723	16
17	21	CLERICAL AND GENERAL WA	AVAIL. BED DAYS	1,918,919	34	11,883,371	11,883,371	68,620	424,946	17
18	21	CLERICAL AND OFFICE EXPEI	AVAIL. BED DAYS	1,918,919	34	343,715		68,620	12,291	18
19	24	EDUCATION AND SEMINARS	AVAIL. BED DAYS	1,918,919	34	96,819		68,620	3,462	19
20	26	INSURANCE- GENERAL	AVAIL. BED DAYS	1,918,919	34	164,496		68,620	5,882	20
21	27	NON-NURSING PAYROLL TAXI	AVAIL. BED DAYS	1,918,919	34	1,852,008		68,620	66,227	21
22	32	INTEREST	AVAIL. BED DAYS	1,918,919	34	1,074		68,620	38	22
23	34	RENT	AVAIL. BED DAYS	1,918,919	34	1,359,900		68,620	48,630	23
24	34	OFFSITE STORAGE/PARKING	AVAIL. BED DAYS	1,918,919	34	5,072		68,620	181	24
25	TOTALS					$ 21,787,253	$ 17,394,136		$ 779,106	25

Facility Name & ID Number Peterson Park Hc Ctr # 0024463 Report Period Beginning: 01/01/18 Ending: 12/31/18

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization: Legacy Healthcare Financial Services
Street Address: 3450 Oakton Street
City / State / Zip Code: Skokie, IL 60076
Phone Number: (847) 679-9797
Fax Number: (847) 683-2900

	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	35	EQUIPMENT RENTAL	AVAIL. BED DAYS	1,918,919	34	7,088		68,620	253	1
2	35	AUTO RENTAL	AVAIL. BED DAYS	1,918,919	34	125,028		68,620	4,471	2
3	15	NURSING PAYROLL TAXES/BE	AVAIL. BED DAYS	1,918,919	34	253,092		68,620	9,051	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					$ 385,208	$		$ 13,775	25

Facility Name & ID Number Peterson Park Hc Ctr # 0024463 Report Period Beginning: 01/01/18 Ending: 12/31/18

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: CF St. Louis LLC
Street Address: 3450 Oakton Street
City / State / Zip Code: Skokie, IL 60076
Phone Number: (847) 676-5300
Fax Number: (847) 676-5348

	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	5	UTILITIES	AVAIL. BED DAYS	1,916,917	34	$ 32,982	$	68,620	$ 1,181	1
2	6	REPAIRS & MAINTENANCE	AVAIL. BED DAYS	1,916,917	34	44,396		68,620	1,589	2
3	19	PROFESSIONAL FEES	AVAIL. BED DAYS	1,916,917	34	1,378		68,620	49	3
4	20	DUES & SUBSCRIPTIONS	AVAIL. BED DAYS	1,916,917	34	23		68,620	1	4
5	21	OFFICE EXPENSE	AVAIL. BED DAYS	1,916,917	34	10,860		68,620	389	5
6	26	INSURANCE	AVAIL. BED DAYS	1,916,917	34	12,721		68,620	455	6
7	32	INTEREST EXPENSE	AVAIL. BED DAYS	1,916,917	34	157,106		68,620	5,624	7
8	33	REAL ESTATE TAXES	AVAIL. BED DAYS	1,916,917	34	149,528		68,620	5,353	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					$ 408,994	$		$ 14,640	25

Facility Name & ID Number Peterson Park Hc Ctr # 0024463 Report Period Beginning: 01/01/18 Ending: 12/31/18

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: ML Group Design and Development
Street Address: 3424 Oakton St
City / State / Zip Code: Skokie, IL 60077
Phone Number: (847) 676-5300
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	06	Maintenance	Direct			$	$		$ 32,359	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					$	$		$ 32,359	25

Facility Name & ID Number Peterson Park Hc Ctr # 0024463 Report Period Beginning: 01/01/18 Ending: 12/31/18

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: ProPay HR LLC
Street Address: 2201 W. MAIN ST
City / State / Zip Code: EVANSTON , ILLINOIS 60202
Phone Number: (847) 905 3268
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	19	Payroll Services	Direct			$	$		$ 27,428	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					$	$		$ 27,428	25

Facility Name & ID Number Peterson Park Hc Ctr # 0024463 Report Period Beginning: 01/01/18 Ending: 12/31/18

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: ReMED Services LLC
Street Address: 3424 Oakton St Suite 102
City / State / Zip Code: Skokie, IL 60077
Phone Number: (847) 440-2600
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	10	Medical Supplies	Direct			$	$		$ 8,730	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					$	$		$ 8,730	25

Facility Name & ID Number Peterson Park Hc Ctr # 0024463 Report Period Beginning: 01/01/18 Ending: 12/31/18

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: EcoBrite Linen
Street Address: 3712 Jarvis Avenue
City / State / Zip Code: Skokie, IL 60076
Phone Number: (847) 582-4000
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	04	Laundry Services	Direct			$	$		$ 221,186	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					$	$		$ 221,186	25

Facility Name & ID Number Peterson Park Hc Ctr # 0024463 Report Period Beginning: 01/01/18 Ending: 12/31/18

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization: Shabat & Associates Inc.
Street Address: 3450 Oakton Avenue
City / State / Zip Code: Skokie, IL 60076
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	17	Salary - Ron Shabat	Direct			$	$		$ 250,000	1
2	27	Payroll Taxes	Direct						11,696	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					$	$		$ 261,696	25

Facility Name & ID Number Peterson Park Hc Ctr # 0024463 Report Period Beginning: 01/01/18 Ending: 12/31/18

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: 01/01/18 Ending: 12/31/18

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	Capital One		X	Mortgage	$33,404.55	7/1/12	$ 5,545,100	$ 3,796,281	11/1/29	0.0265	$ 104,214	1
2												2
3												3
4												4
5												5
	Working Capital											
6	Bank Financial		X	Line of Credit				1,251,010			55,882	6
7	Allocated from Legacy HC		X								38	7
8	Allocated from CF St. Louis		X								5,624	8
9	TOTAL Facility Related				$33,404.55		$ 5,545,100	$ 5,047,290			$ 165,758	9
	B. Non-Facility Related*											
10	Interest Income		X								(34,290)	10
11	Interest Income - Bldg Co		X								(207)	11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (34,497)	14
15	TOTALS (line 9+line14)						$ 5,545,100	$ 5,047,290			$ 131,261	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ 19,657 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: 01/01/18 Ending: 12/31/18

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2017 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 303,935	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.)		$ 331,999	2
3. Under or (over) accrual (line 2 minus line 1).		$ 28,064	3
4. Real Estate Tax accrual used for 2018 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 326,646	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$ 5,505	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 360,215	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2013	261,507	8
	2014	266,087	9
	2015	285,486	10
	2016	309,328	11
	2017	326,646	12

Beginning Accrual Adjusted
Allocated from CF St. Louis: $5,353
2018 Accrual = 2017 Tax

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2017	$	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.

2017 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

TELEPHONE (847) 282-6300 FAX #: (847) 282-6301

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

Enter the tax index number and real estate tax assessed for 2017 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 2017.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	13-02-115-052-0000	Long Term Care Property	$ 326,645.95	$ 326,645.95
2.	10-23-406-034-0000	Home Office Allocation	$ 492,481.94	$ 5,352.66
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 819,127.89	$ 331,998.61

B. **Real Estate Tax Cost Allocations**

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

If YES, attach an explanation 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 2017 tax bills which were listed in Section A to this statement. Be sure to use the 2017 tax bill which is normally paid during 2018.

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

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates
RE: 2017 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2017 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2017.

Please complete the Real Estate Tax Statement below and include it in the 2018 cost report along with a copy of your 2017 real estate tax bill.

The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2017 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

TELEPHONE (847) 282-6300 FAX #: (847) 282-6301

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

Enter the tax index number and real estate tax assessed for 2017 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 2017.

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

B. **Real Estate Tax Cost Allocations**

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

If YES, attach an explanation 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 2017 tax bills which were listed in Section A to this statement. Be sure to use the 2017 tax bill which is normally paid during 2018.

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: 01/01/18 Ending: 12/31/18

X. BUILDING AND GENERAL INFORMATION:

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

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

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

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

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

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

None

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

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

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

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

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility			$ 283,071	1
2	Allocated from CF St. Louis, LLC			7,065	2
3	TOTALS			$ 290,136	3

Facility Name & ID Number Peterson Park Hc Ctr # 0024463 Report Period Beginning: 01/01/18 Ending: 12/31/18

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	196		1986	1976	$ 2,548,850	$ 229,126	35	$ 72,824	$ (156,302)	$ 2,332,368	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			1979	4,800		20				9
10	Various			1981	57,728		20				10
11	Various			1982	11,967		20				11
12	Various			1983	3,440		20				12
13	Various			1984	12,700		20				13
14	Various			1985	98,707		20				14
15	Various			1986	42,087		20				15
16	Various			1987	17,729		20	886	886	17,729	16
17	Various			1988	35,577		20	1,779	1,779	35,423	17
18	Various			1989	14,951		20	748	748	14,097	18
19	Various			1990	27,693		20	1,385	1,385	25,568	19
20	Various			1991	62,352		20	3,118	3,118	62,352	20
21	Various			1992	10,152		20	508	508	10,152	21
22	Various			1993	21,815		20	1,091	1,091	21,815	22
23	Various			1994	264,384		20	13,219	13,219	264,384	23
24	Various			1995	103,507		20	5,175	5,175	103,507	24
25	Various			1996	35,086		20	1,754	1,754	35,086	25
26	Various			1997	62,950		20	3,148	3,148	62,950	26
27	Various			1998	49,698		20	2,485	2,485	49,698	27
28	Various			1999	87,532		20	4,377	4,377	86,854	28
29	Various			2000	189,224		20	9,422	9,422	174,622	29
30	Various			2001	73,918		20	3,696	3,696	65,378	30
31	Various			2002	350,099		20	17,505	17,505	288,865	31
32	Various			2003	68,436		20	3,912	3,912	58,700	32
33	Various			2004	49,148		20	3,309	3,309	46,345	33
34	Various			2005	49,872		20	2,692	2,692	34,725	34
35	Various			2006	22,247		20	2,530	2,530	27,929	35
36	Various			2007	369,261		20	18,938	18,938	211,299	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: 01/01/18 Ending: 12/31/18

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Various	2008	$ 97,549	$	20	$ 5,102	$ 5,102	$ 45,721	37
38	Various	2009	210,789		20	10,539	10,539	99,194	38
39	Various	2010	598,565		20	37,112	37,112	316,314	39
40	Various	2011	201,262		20	11,108	11,108	79,442	40
41	Various	2012	253,137		20	12,657	12,657	58,911	41
42	Various	2013	141,718		20	7,546	7,546	15,547	42
43	Various	2014	298,652		20	14,933	14,933	71,874	43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67	Related Building Company (Pages 12F & 12G)		112,077			5,604	5,604	5,604	67
68	Related Party Allocations (Pages 12H & 12I)		279,983			13,184	13,184	39,250	68
69	Financial Statement Depreciation								69
70	TOTAL (lines 4 thru 69)		$ 6,939,643	$ 229,126		$ 292,284	$ 63,158	$ 4,761,701	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: 01/01/18 Ending: 12/31/18

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		$ 6,939,643	$ 229,126		$ 292,284	$ 63,158	$ 4,761,701	1
2	New Wiring Circuits Must Be Installed For Each Nursing Station	2015			20				2
3	(Total Of 4), Each Call Station Panel, (Total Of 4), Each Data	2015			20				3
4	Signal Amplifier (Total Of 2), And Each Extra Install 6-Plug	2015			20				4
5	Emergency Outlet (Total Of 2); Disconnect And Remove Existing	2015			20				5
6	Wiring Between Nursing Stations, Outlets, Call Station Panels	2015			20				6
7	Nursing Stations, And Existing Sub-Panels; Make New Electrical	2015			20				7
8	Connections Between The Emergency Panel And Every Nursing	2015			20				8
9	Station Outlet, & Every Call Station Panel (Total Of 4 Call Stations	2015	9,900		20	495	495	1,125	9
10	Chimney And Around Building Tuckponting	2015	2,800		20	140	140	318	10
11	Ac System For Server Room	2015	5,895		20	295	295	671	11
12	Lobby Ac Unit Replacement	2015	11,312		20	566	566	1,285	12
13	Make Up Air Handler Replacement For Common	2015	55,216		20	2,761	2,761	6,275	13
14	Hallway & Kitchen	2015			20				14
15	Entrance Hallway, Lobby And Office Removing	2015			20				15
16	Wallpeper, Patching And Wall Painting	2015	7,425		20	371	371	1,484	16
17	Removing And Installation Of New Carpet For The Main Lobby	2015			20				17
18	Area, And The 3 Offices Surrounding It	2015	8,175		20	409	409	2,830	18
19	6/30/17 Capital Report Adjustments	2015	(55,216)		20				19
20	Replacement Of Cylinder In Passenger Elevator	2016	32,711		20	1,636	1,636	3,172	20
21	8 Door Skins- Material And Installation. Door	2016			20				21
22	Skins On Two Sets Of Double Doors At Main Lobby	2016	4,300		20	215	215	482	22
23	Frigidaire Wall A/C Units With Electric Heat In	2017			20				23
24	8 Resident Rooms On First Floor South Side	2017	3,825		20	191	191	324	24
25	Separated #1 Ahu And #2 Ahu From The Building,	2017			20				25
26	And Dedicated 1 Hydronic Boiler With Glycol	2017			20				26
27	To Heat Air Handler	2017	14,539		20	727	727	1,234	27
28	Air Handler	2017	102,545		20	5,127	5,127	8,701	28
29	8 New Beds- 2 On First Floor And 6 On Second Floor	2017	503,381		20	25,169	25,169	35,084	29
30	Fire Alarm Tie In To City	2017	9,463		20	473	473	487	30
31	Air Handler	2017	59,987		20	2,999	2,999	5,999	31
32	Chiller	2017	97,774		20	4,889	4,889	9,777	32
33	Repaired Copper Line/Concrete Slabs By Staircase-South End ($70	2018	6,553		20	328	328	328	33
34	TOTAL (lines 1 thru 33)		$ 7,820,228	$ 229,126		$ 339,074	$ 109,948	$ 4,841,276	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: 01/01/18 Ending: 12/31/18

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		$ 7,820,228	$ 229,126		$ 339,074	$ 109,948	$ 4,841,276	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 7,820,228	$ 229,126		$ 339,074	$ 109,948	$ 4,841,276	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: 01/01/18 Ending: 12/31/18

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		$ 7,820,228	$ 229,126		$ 339,074	$ 109,948	$ 4,841,276	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 7,820,228	$ 229,126		$ 339,074	$ 109,948	$ 4,841,276	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: 01/01/18 Ending: 12/31/18

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		$ 7,820,228	$ 229,126		$ 339,074	$ 109,948	$ 4,841,276	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 7,820,228	$ 229,126		$ 339,074	$ 109,948	$ 4,841,276	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: 01/01/18 Ending: 12/31/18

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Building Company		$	$		$	$	$	1
2									2
3									3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Awning near Smoke Shelter	2018	3,277		20	164	164	164	9
10	Installed Door & Glass Panels/Drywall/painting in common area	2018	11,015		20	551	551	551	10
11	Installed sliding door on 2nd Floor	2018	12,033		20	602	602	602	11
12	Repaired backflows in custodial closet and kitchen	2018	9,205		20	460	460	460	12
13	Legal Fees/Architect Fees/Permit Fees for 2nd Floor PT Room								13
14	Installed shelving with doors in four section and								14
15	Installed wallpaper, blinds on 2nd Floor PT Room	2018	71,404		20	3,570	3,570	3,570	15
16	Installed egress magnetic lock/fire alarm/cables	2018	2,747		20	137	137	137	16
17	Recreation Room-Install 2 base & 4 wall cabinets, laminate top	2018	2,397		20	120	120	120	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)		$ 112,077	$		$ 5,604	$ 5,604	$ 5,604	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: 01/01/18 Ending: 12/31/18

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		$ 112,077	$		$ 5,604	$ 5,604	$ 5,604	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
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19									19
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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)		$ 112,077	$		$ 5,604	$	$ 5,604	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: 01/01/18 Ending: 12/31/18

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Related Party		$	$		$	$	$	1
2	Buildings:								2
3	Allocated from CF St. Louis, LLC	2016	38,041		35	1,087	1,087	3,261	3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Allocated from CF St. Louis, LLC	2016	236,179		20	11,809	11,809	35,427	9
10	Allocated from CF St. Louis, LLC	2017	5,482		20	274	274	548	10
11									11
12									12
13	Allocated from Legacy HC	2018	282		20	14	14	14	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)		$ 279,983	$		$ 13,184	$ 13,184	$ 39,250	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: 01/01/18 Ending: 12/31/18

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 12H, Carried Forward		$ 279,983	$		$ 13,184	$ 13,184	$ 39,250	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 279,983	$		$ 13,184	$ 13,184	$ 39,250	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: 01/01/18 Ending: 12/31/18

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 2,063,212	$	$ 206,321	$ 206,321	10	$ 1,879,309	71
72	Current Year Purchases	27,677		2,768	2,768	10	2,768	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 2,090,889	$	$ 209,089	$ 209,089		$ 1,882,077	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)	$ 10,201,253	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 229,126	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 548,163	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 319,037	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 6,723,353	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: 01/01/18 Ending: 12/31/18

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

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

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5	Allocated from Legacy HC				181			5
6								6
7	TOTAL				$ 181 **			7

10. Effective dates of current rental agreement:
    Beginning
    Ending

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

	Fiscal Year Ending	Annual Rent
12.	/2019	$
13.	/2020	$
14.	/2021	$

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

9. Option to Buy: ☐ YES ☐ NO Terms: *

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

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO
16. Rental Amount for movable equipment: $ 7,123 Description: See Attached Schedule
    (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Allocated from Legacy HC		$	$ 4,471	17
18					18
19					19
20					20
21	TOTAL		$	$ 4,471	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: 01/01/18 Ending: 12/31/18

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

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

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

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF CNAs TRAINED

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

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

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 - 03	hrs	$		$ 277,858	$		$ 277,858	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			98,790			98,790	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			327,342			327,342	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 02	# of prescrpts				134,666		134,666	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):					59,299	242,944		302,243	13
14	TOTAL			$		$ 763,289	$ 377,610		$ 1,140,899	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.

STATE OF ILLINOIS

Facility Name & ID Number Peterson Park Hc Ctr # 0024463 Report Period Beginning: 01/01/18 Ending: 12/31/18

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/18 (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	$ 51,796	$ 55,572	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,386,493	1,386,493	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	24,307	41,503	6
7	Other Prepaid Expenses	10,889	10,889	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Attached Schedule	49,042	607,506	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,522,527	$ 2,101,963	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	7,080	4,718,553	15
16	Equipment, at Historical Cost		2,282,095	16
17	Accumulated Depreciation (book methods)	72,112	(6,483,581)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See Attached Schedule	4,131,399	879,317	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 4,210,591	$ 4,047,718	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 5,733,118	$ 6,149,681	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 1,815,300	$ 1,824,798	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	479,181	479,181	30
31	Accrued Taxes Payable (excluding real estate taxes)	20,115	20,115	31
32	Accrued Real Estate Taxes(Sch.IX-B)		326,646	32
33	Accrued Interest Payable		8,383	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached Schedule	71,368	71,368	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 2,385,964	$ 2,730,491	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	1,251,010	5,047,291	39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 1,251,010	$ 5,047,291	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 3,636,974	$ 7,777,782	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 2,096,144	$ (1,628,101)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 5,733,118	$ 6,149,681	48

*(See instructions.)

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XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,955,336	1
2	Restatements (describe):		2
3	Rounding	3	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,955,339	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	140,805	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 140,805	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 2,096,144	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	$ 19,396,279	1
2	Discounts and Allowances for all Levels	(8,390,021)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 11,006,258	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,699,342	6
7	Oxygen	617	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 2,699,959	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	134,715	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	16,348	19
20	Radiology and X-Ray		20
21	Other Medical Services	33,983	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 185,046	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	34,290	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 34,290	26
	E. Other Revenue (specify):**		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28	See Supplemental Schedule	18,543	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 18,543	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 13,944,096	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	2,041,932	31
32	Health Care	5,636,845	32
33	General Administration	3,453,596	33
	B. Capital Expense		
34	Ownership	1,060,747	34
	C. Ancillary Expense		
35	Special Cost Centers	1,140,899	35
36	Provider Participation Fee	469,272	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 13,803,291	40
41	**Income before Income Taxes (line 30 minus line 40)****	140,805	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 140,805	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 11,006,258	44
45	Private Pay - Net Inpatient Revenue		45
46	Medicare - Net Inpatient Revenue		46
47	Other-(specify)		47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 11,006,258	49

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

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

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

****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	1,776	2,160	$ 115,532	$ 53.49	1
2	Assistant Director of Nursing	1,952	2,160	98,933	45.80	2
3	Registered Nurses	45,731	50,550	1,681,297	33.26	3
4	Licensed Practical Nurses	26,706	29,472	854,074	28.98	4
5	CNAs & Orderlies	111,254	119,640	1,653,388	13.82	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	14,488	15,752	299,569	19.02	8
9	Activity Director	2,547	2,651	51,919	19.58	9
10	Activity Assistants	12,476	13,827	173,634	12.56	10
11	Social Service Workers	10,872	11,983	304,404	25.40	11
12	Dietician	3,360	3,520	92,207	26.20	12
13	Food Service Supervisor	1,848	2,056	55,094	26.80	13
14	Head Cook	7,264	8,534	157,725	18.48	14
15	Cook Helpers/Assistants	20,254	21,730	280,881	12.93	15
16	Dishwashers					16
17	Maintenance Workers	4,515	4,862	100,039	20.57	17
18	Housekeepers	17,475	19,519	259,833	13.31	18
19	Laundry	432	472	6,873	14.56	19
20	Administrator	2,008	2,220	112,013	50.46	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	17,635	20,032	359,449	17.94	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	1,856	2,080	45,464	21.86	31
32	Other Health Care(specify)					32
33	Other(specify) See Attached	2,000	2,168	43,121	19.89	33
34	TOTAL (lines 1 - 33)	306,448	335,389	$ 6,745,449 *	$ 20.11	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	$ 5,910	01-03	35
36	Medical Director	Monthly	30,816	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant	Monthly	50,129	10-03	38
39	Pharmacist Consultant	Monthly	13,052	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	Monthly	4,371	11-03	44
45	Social Service Consultant	Monthly	5,769	12-03	45
46	Other(specify)				46
47	Psychiatric Consultant	Monthly	7,040	12-03	47
48					48
49	TOTAL (lines 35 - 48)		$ 117,087		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	84	$ 4,200	10-03	50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	84	$ 4,200		53

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Jonathan Dauber	Administrator	0.00%	$ 72,668
Patricia D. Davis	Administrator	0.00%	39,326
Shalom Lichtman	Administrator	0.00%	18
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 112,012

B. Administrative - Other

Description	Amount
Shabat and Associates	$ 660,000
TOTAL (agree to Schedule V, line 17, col. 3)	$ 660,000
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Krupnick Bokor Kagda & Brooks	Accounting	$ 24,939
Compliance Resource	Compliance	169
ProPay HR	Payroll Processing	37,156
Achieve Accreditation	Accreditation	9,744
IIT/Source Tech	Data Processing	1,495
Adam Zollinger	Interior Design	6,960
Integra Scripts LLC	Data Processing	500
Michigan Peer Review Organization	Quality Improvement	753
MTS Consulting	Tax Consulting	1,464
Personnel Planners	Unemployment Tax Consultant	1,612
Prospect Resources	Energy Procurement	800
See Supplemental Schedule		314,728
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 400,319

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 142,175
Unemployment Compensation Insurance	37,374
FICA Taxes	482,546
Employee Health Insurance	318,197
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Union Pension	51,264
401K Expense	15,269
Employee Physical Exams	12,340
Other Employee Benefits	15,649
TOTAL (agree to Schedule V, line 22, col.8)	$ 1,074,814

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

Description	Line #	Amount
		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	
Health Care Worker Background Check	613
(Indicate # of checks performed 61)	
Patient Background Checks 572	5,720
Dues and Subscriptions	21,790
License and Permits	5,426
Allocated from Legacy HC	723
Allocated from CF St. Louis	1
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 34,272

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	4,494
Allocated from Legacy HC	3,462
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 7,956

**See instructions.

Facility Name & ID Number Peterson Park Hc Ctr # 0024463 Report Period Beginning: 01/01/18 Ending: 12/31/18

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. **Health Care Council of Illinois $28,350**

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

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

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

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **40,433** Line **10-2**

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

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

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

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

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **469,272**
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. $ 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. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **100% Ln 14**
d. Have vehicle usage logs been maintained? **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: **N/A**

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **Yes**

(19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. **Yes**
Attach invoices and a summary of services for all architect and appraisal fees