FOR BHF USE

LL1

2020
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2020)

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.

I. IDPH License ID Number: 0024463

Facility Name: Peterson Park Heath Care Ctr

Address: 6141 N 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 01/01/20 to 12/31/20 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) 04/29/2021 (Date)
** Subject to the attached Accountants' Consulting Report*
(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 Heath Care Ctr # 0024463 Report Period Beginning: 01/01/20 Ending: 12/31/20

III. STATISTICAL DATA

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

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	196	Skilled (SNF)	196	71,736	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	196	TOTALS	196	71,736	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	50,252	2,091	6,974	59,317	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	50,252	2,091	6,974	59,317	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 82.69%

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 4,310

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

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

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

Tax Year: 12/31/2020 Fiscal Year: 12/31/2020

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

Facility Name & ID Number Peterson Park Heath Care Ctr # 0024463 Report Period Beginning: 01/01/20 Ending: 12/31/20

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	606,906	87,713		694,619		694,619	3,549	698,168			1
2	Food Purchase		529,167		529,167		529,167	3,453	532,620			2
3	Housekeeping	230,464	32,191	2,565	265,220		265,220	2,301	267,521			3
4	Laundry	95,920	27,907	172,459	296,286		296,286	156	296,442			4
5	Heat and Other Utilities			172,274	172,274		172,274	(9,352)	162,922			5
6	Maintenance	97,580	16,298	143,313	257,191		257,191	6,137	263,328			6
7	Other (specify):*											7
8	**TOTAL General Services**	1,030,870	693,276	490,611	2,214,757		2,214,757	6,245	2,221,002			8
	B. Health Care and Programs											
9	Medical Director			16,000	16,000		16,000		16,000			9
10	Nursing and Medical Records	5,338,852	261,940	54,522	5,655,314		5,655,314	112,637	5,767,951			10
10a	Therapy	362,531		250	362,781		362,781		362,781			10a
11	Activities	177,979	4,222	945	183,146		183,146	9	183,155			11
12	Social Services	503,340		3,696	507,036		507,036	6,164	513,200			12
13	CNA Training											13
14	Program Transportation			28,985	28,985		28,985		28,985			14
15	Other (specify):*							6,393	6,393			15
16	**TOTAL Health Care and Programs**	6,382,702	266,162	104,398	6,753,262		6,753,262	125,204	6,878,466			16
	C. General Administration											
17	Administrative	100,908		969,000	1,069,908		1,069,908	(650,383)	419,525			17
18	Directors Fees											18
19	Professional Services			725,357	725,357	(811)	724,546	(548,862)	175,683			19
20	Dues, Fees, Subscriptions & Promotions			139,114	139,114		139,114	(92,496)	46,618			20
21	Clerical & General Office Expenses	263,182	2,754	447,808	713,744		713,744	(8,831)	704,913			21
22	Employee Benefits & Payroll Taxes			1,305,260	1,305,260		1,305,260		1,305,260			22
23	Inservice Training & Education											23
24	Travel and Seminar			218	218		218	153	371			24
25	Other Admin. Staff Transportation			209	209		209	5,130	5,339			25
26	Insurance-Prop.Liab.Malpractice			385,822	385,822		385,822	11,862	397,684			26
27	Other (specify):*							39,198	39,198			27
28	**TOTAL General Administration**	364,090	2,754	3,972,788	4,339,632	(811)	4,338,821	(1,244,230)	3,094,591			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	7,777,662	962,192	4,567,797	13,307,651	(811)	13,306,840	(1,112,781)	12,194,059			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 Heath Care Ctr #0024463 Report Period Beginning: 01/01/20 Ending: 12/31/20

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							307,359	307,359			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			41,090	41,090		41,090	66,672	107,762			32
33	Real Estate Taxes					811	811	405,726	406,537			33
34	Rent-Facility & Grounds			954,896	954,896		954,896	(954,789)	107			34
35	Rent-Equipment & Vehicles			7,850	7,850		7,850	4,983	12,833			35
36	Other (specify):*							16,615	16,615			36
37	**TOTAL Ownership**			1,003,836	1,003,836	811	1,004,647	(153,433)	851,214			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		411,342	934,530	1,345,872		1,345,872	(11,554)	1,334,318			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			456,504	456,504		456,504		456,504			42
43	Other (specify):*			1,174	1,174		1,174	(1,174)	(0)			43
44	**TOTAL Special Cost Centers**		411,342	1,392,208	1,803,550		1,803,550	(12,728)	1,790,822			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	7,777,662	1,373,534	6,963,841	16,115,037		16,115,037	(1,278,943)	14,836,094			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 Heath Care Ctr # 0024463 Report Period Beginning: 01/01/20 Ending: 12/31/20

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	(10,552)	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	117,526	30		9
10	Interest and Other Investment Income	(25,250)	32		10
11	Discounts, Allowances, Rebates & Refunds	(3,112)	02		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(186)	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	(218)	21		18
19	Entertainment	(320)	21		19
20	Contributions	(68,003)	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	(281,464)	21		24
25	Fund Raising, Advertising and Promotional	(8,823)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(378,157)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (658,559)		$	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)	(620,383)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (620,383)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (1,278,942)		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 Heath Care Ctr

ID# 0024463

Report Period Beginning: 01/01/20

Ending: 12/31/20

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Patient Personal Items	$ (2,875)	10	1
2	Bank Charges	(660)	21	2
3	Sequestration Expense	(23,465)	21	3
4	Miscellaneous Income	(27)	21	4
5	Building Co - Filing Fees	(991)	20	5
6	Building Co - Accounting Fees	(16,774)	19	6
7	Building Co - Amortization	(7,719)	36	7
8	Capitalized R&M	(5,767)	06	8
9	Non-Allowable Expense	(1,174)	43	9
10	PAC Dues	(19,517)	20	10
11	Non-Allowable Legal	(299,188)	19	11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(378,157)		49

Detail lines 29 and 35 of Page 5 starting in C12. **DO NOT DRAG AND DROP CELLS.**

The amounts in column F will transfer to the Adj. Summary column automatically.
The amounts in the Adj. Summary column are linked to pages Summary A and B.

STATE OF ILLINOIS **Page 5B**

Peterson Park Health Care Ctr

IDF 0024463

Report Period Beginning: 01/01/20

Ending: 12/31/20

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
50		b		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

Reference 1	Reference 2	Reference 3	Reference 4	Reference 5	Reference 6	Reference 7	Reference 9	Reference 10	Reference 10a	Reference 11	Reference 12	Reference 13	Reference 14	Reference 15	Reference 17	Reference 18	Reference 19	Reference 20	Reference 21	Reference 22	Reference 23	Reference 24	Reference 25	Reference 26	Reference 27	Reference 30	Reference 31	Reference 32	Reference 33	Reference 34	Reference 35	Reference 36	Reference 38	Reference 39	Reference 40	Reference 41	Reference 42	Reference 43

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Peterson Park Heath Care Ctr # 0024463 Report Period Beginning: 01/01/20 Ending: 12/31/20

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			3,549									3,549	1
2	Food Purchase	(3,298)		6,751									3,453	2
3	Housekeeping			2,301									2,301	3
4	Laundry			156									156	4
5	Heat and Other Utilities	(10,552)				1,200							(9,352)	5
6	Maintenance	(5,767)		11,535		1,163	(794)						6,137	6
7	Other (specify):*													7
8	**TOTAL General Services**	(19,617)		24,293		2,363	(794)						6,245	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(2,875)		117,999				(2,487)					112,637	10
10a	Therapy													10a
11	Activities			9									9	11
12	Social Services			6,164									6,164	12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*				6,393								6,393	15
16	**TOTAL Health Care and Programs**	(2,875)		124,172	6,393			(2,487)					125,204	16
	C. General Administration													
17	Administrative			68,617						(719,000)			(650,383)	17
18	Directors Fees													18
19	Professional Services	(315,962)	16,774	(241,474)		505			(8,706)				(548,862)	19
20	Fees, Subscriptions & Promotions	(97,334)	991	3,846		1							(92,496)	20
21	Clerical & General Office Expenses	(306,154)		297,044		279							(8,831)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar			153									153	24
25	Other Admin. Staff Transportation			5,130									5,130	25
26	Insurance-Prop.Liab.Malpractice		11,425	135		301							11,862	26
27	Other (specify):*			27,502						11,696			39,198	27
28	**TOTAL General Administration**	(719,450)	29,191	160,954		1,086			(8,706)	(707,304)			(1,244,230)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(741,942)	29,191	309,419	6,393	3,449	(794)	(2,487)	(8,706)	(707,304)			(1,112,781)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Peterson Park Heath Care Ctr # 0024463 Report Period Beginning: 01/01/20 Ending: 12/31/20

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	117,526	182,431			7,402							307,359	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(25,250)	87,763			4,160							66,672	32
33	Real Estate Taxes		401,947			3,779							405,726	33
34	Rent-Facility & Grounds		(954,896)	34,833		(34,726)							(954,789)	34
35	Rent-Equipment & Vehicles				4,983								4,983	35
36	Other (specify):*	(7,719)	24,334										16,615	36
37	**TOTAL Ownership**	84,557	(258,421)	34,833	4,983	(19,385)							(153,433)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers											(11,554)	(11,554)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(1,174)											(1,174)	43
44	**TOTAL Special Cost Centers**	(1,174)										(11,554)	(12,728)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(658,559)	(229,231)	344,252	11,376	(15,936)	(794)	(2,487)	(8,706)	(707,304)		(11,554)	(1,278,943)	45

Facility Name & ID Number Peterson Park Heath Care Ctr # 0024463 Report Period Beginning: 01/01/20 Ending: 12/31/20

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	$ 954,896	Peterson Park Realty		$	$ (954,896)	1
2	V	32	Interest	323	Peterson Park Realty		88,086	87,763	2
3	V	33	RE Taxes		Peterson Park Realty		401,947	401,947	3
4	V	26	Insurance		Peterson Park Realty		11,425	11,425	4
5	V	36	MIP Insurance		Peterson Park Realty		16,615	16,615	5
6	V	20	Filing Fees		Peterson Park Realty		991	991	6
7	V	19	Accounting		Peterson Park Realty		16,774	16,774	7
8	V	36	Amortization		Peterson Park Realty		7,719	7,719	8
9	V	30	Depreciation		Peterson Park Realty		182,431	182,431	9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 955,219			$ 725,988	$ * (229,231)	14

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

Facility Name & ID Number Peterson Park Heath Care Ctr # 0024463 Report Period Beginning: 01/01/20 Ending: 12/31/20

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		Building Company	1
2	Menachem Shabat	9.04%	Avantara Arlington	Arlington, SD	Legacy HC & Financial Services	Lincolnwood	Home Office/Bookkeeping	2
3	Jack Rajchenbach	9.57%	Avantara Armour	Armour, SD	CF St. Louis LLC	Skokie	Building Company	3
4	Ronald Shabat	69.15%	Avantara Arrowhead	Rapid City, SD	ML Group Design & Development	Skokie	Asset Management	4
5	PPA, LTD.	5.32%	Avantara Aurora	Aurora	ReMED Services LLC	Lincolnwood	Nursing Equipment	5
6	Ahuva Shabat	1.60%	Avantara Billings	Billings, MT	Propay HR	Evanston	Payroll Processing	6
7			Avantara Clark	Clark, SD	Ecobrite Linen	Skokie	Laundry Supplies	7
8			Avantara Elgin	Elgin	Aurora Supportive Living	Aurora	Supportive Living	8
9			Avantara Evergreen Park	Evergreen Park	Terrace Gardens	Morton Grove	Assisted Living	9
10			Avantara Groton	Groton, SD	Lincolnshire Assisted Living Center	Lincolnshire	Assisted Living	10
11			Avantara Huron	Huron, SD	Wellshire Park Place	Milbank, SD	Assisted Living	11
12			Avantara Ipswich	Ipswich, SD	Wellshire Huron	Huron, SD	Assisted Living	12
13			Avantara Lake Norden	Lake Norden, SD	Lifescan Labs of Illinois	Skokie	Laboratory	13
14			Avantara Long Grove	Long Grove				14
15			Avantara Milbank	Milbank, SD				15
16			Avantara Mountainview	Rapid City, SD				16
17			Avantara North	Rapid City, SD				17
18			Avantara Norton	Sioux Falls, SD				18
19			Avantara Park Ridge	Park Ridge				19
20			Avantara Pierre	Pierre, SD				20
21			Avantara Redfield	Redfield, SD				21
22			Avantara Salem	Salem, SD				22
23			Avantara St. Cloud	Rapid City, SD				23
24			Avantara Watertown	Watertown, SD				24
25			Bella Terra Streamwood	Streamwood				25
26			Bella Terra Wheeling	Wheeling				26
27			Bethany Terrace	Morton Grove				27
28			Carlton Skilled Nursing Facility LLC	Chicago				28
29			Chalet Skilled Nursing Facility LLC	Chicago				29
30			Clark Skilled Nursing Facility	Chicago				30

Facility Name & ID Number Peterson Park Heath Care Ctr # 0024463 Report Period Beginning: 01/01/20 Ending: 12/31/20

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			Elmbrook Skilled Nursing Facility LLC	Elmhurst				1
2			Evanston Skilled Nursing Facility LLC	Evanston				2
3			Grove at the Lake Skilled Nursing Facility LLC	Zion				3
4			Grove of Berwyn	Berwyn				4
5			Grove of Fox Valley	Aurora				5
6			Grove of St. Charles	St. Charles				6
7			Lagrange Skilled Nursing Facility LLC	Lagrange Park				7
8			Lakefront Skilled Nursing Facility LLC	Chicago				8
9			Lincoln Park Skilled Nursing Facility LLC	Chicago				9
10			Lincolnshire Living & Rehab Center LLC	Lincolnshire				10
11			Northbrook Skilled Nursing Facility LLC	Northbrook				11
12			Skokie Skilled Nursing Facility LLC	Skokie				12
13			Valley Skilled Nursing Facility	Billings, MT				13
14			Warren Barr Living And Rehab	Chicago				14
15			Warren Barr North Shore	Highland Park				15
16			Warren Barr South Loop	Chicago				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 Heath Care Ctr # 0024463 Report Period Beginning: 01/01/20 Ending: 12/31/20

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		$ 3,530	$ 3,530	15
16	V	01	Dietary Supplies		Legacy Healthcare Financial Services		19	19	16
17	V	02	Food		Legacy Healthcare Financial Services		6,751	6,751	17
18	V	03	Housekeeping		Legacy Healthcare Financial Services		2,301	2,301	18
19	V	04	Linen Replacement		Legacy Healthcare Financial Services		156	156	19
20	V	06	Maintenance Salary		Legacy Healthcare Financial Services		10,889	10,889	20
21	V	06	Repairs & Maintenance		Legacy Healthcare Financial Services		646	646	21
22	V	10	Nursing Salary		Legacy Healthcare Financial Services		90,129	90,129	22
23	V	10	Nurse/Medical Director Consultant		Legacy Healthcare Financial Services		8,507	8,507	23
24	V	10	Medical Supplies		Legacy Healthcare Financial Services		19,363	19,363	24
25	V	12	Social Service Salary		Legacy Healthcare Financial Services		6,140	6,140	25
26	V	11	Activities Program		Legacy Healthcare Financial Services		9	9	26
27	V	12	Social Service Consultant		Legacy Healthcare Financial Services		24	24	27
28	V	17	COO / Administrative Salary		Legacy Healthcare Financial Services		68,617	68,617	28
29	V	19	Professional Fees	264,000	Legacy Healthcare Financial Services		22,526	(241,474)	29
30	V	20	Dues / Licenses / Permits		Legacy Healthcare Financial Services		3,846	3,846	30
31	V	21	Clerical & General Wages		Legacy Healthcare Financial Services		276,855	276,855	31
32	V	21	Clerical & Office Expense		Legacy Healthcare Financial Services		20,189	20,189	32
33	V	24	Education & Seminars		Legacy Healthcare Financial Services		153	153	33
34	V	25	Travel		Legacy Healthcare Financial Services		5,130	5,130	34
35	V	26	Insurance - General		Legacy Healthcare Financial Services		135	135	35
36	V	27	Non-Nursing Payroll Taxes / Benefits		Legacy Healthcare Financial Services		27,502	27,502	36
37	V	34	Rent		Legacy Healthcare Financial Services		34,726	34,726	37
38	V	34	Offsite Storage / Parking		Legacy Healthcare Financial Services		107	107	38
39	Total			$ 264,000			$ 608,252	$ * 344,252	39

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

Facility Name & ID Number Peterson Park Heath Care Ctr # 0024463 Report Period Beginning: 01/01/20 Ending: 12/31/20

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		463	$ 463	15
16	V	35	Auto Rental		Legacy Healthcare Financial Services		4,520	4,520	16
17	V	15	Nursing Payroll Taxes / Benefits		Legacy Healthcare Financial Services		6,393	6,393	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			$			$ 11,376	$ * 11,376	39

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

Facility Name & ID Number Peterson Park Heath Care Ctr # 0024463 Report Period Beginning: 01/01/20 Ending: 12/31/20

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		$ 1,200	$ 1,200	15
16	V	6	Repairs & Maintenance		CF St. Louis LLC		1,163	1,163	16
17	V	19	Property Valuation Fee		CF St. Louis LLC		411	411	17
18	V	19	Accounting Fees		CF St. Louis LLC		94	94	18
19	V	20	Dues & Subscriptions		CF St. Louis LLC		1	1	19
20	V	21	Office Expense		CF St. Louis LLC		279	279	20
21	V	26	Insurance		CF St. Louis LLC		301	301	21
22	V	30	Depreciation		CF St. Louis LLC		7,402	7,402	22
23	V	32	Interest Expense		CF St. Louis LLC		4,160	4,160	23
24	V	33	Real Estate Taxes		CF St. Louis LLC		3,779	3,779	24
25	V								25
26	V	34	Rent	34,726	CF St. Louis LLC			(34,726)	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			$ 34,726			$ 18,790	$ * (15,936)	39

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

Facility Name & ID Number Peterson Park Heath Care Ctr # 0024463 Report Period Beginning: 01/01/20 Ending: 12/31/20

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	$ 32,400	ML Group Design & Development		$ 31,606	$ (794)	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			$ 32,400			$ 31,606	$ * (794)	39

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

Facility Name & ID Number Peterson Park Heath Care Ctr # 0024463 Report Period Beginning: 01/01/20 Ending: 12/31/20

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	$ 8,250	ReMED Services		$ 5,763	$ (2,487)	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			$ 8,250			$ 5,763	$ * (2,487)	39

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

Facility Name & ID Number Peterson Park Heath Care Ctr # 0024463 Report Period Beginning: 01/01/20 Ending: 12/31/20

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 Services	$ 38,001	ProPay HR LLC		$ 29,295	$ (8,706)	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			$ 38,001			$ 29,295	$ * (8,706)	39

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

Facility Name & ID Number Peterson Park Heath Care Ctr # 0024463 Report Period Beginning: 01/01/20 Ending: 12/31/20

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	969,000	Shabat & Associates			(969,000)	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			$ 969,000			$ 261,696	$ * (707,304)	39

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

Facility Name & ID Number Peterson Park Heath Care Ctr # 0024463 Report Period Beginning: 01/01/20 Ending: 12/31/20

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	$ 172,459	EcoBrite Linen		$ 172,459	$	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			$ 172,459			$ 172,459	$ *	39

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

Facility Name & ID Number Peterson Park Heath Care Ctr # 0024463 Report Period Beginning: 01/01/20 Ending: 12/31/20

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	39	Laboratory	$ 28,389	Lifescan Labs of Illinois		$ 16,835	$ (11,554)	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			$ 28,389			$ 16,835	$ * (11,554)	39

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

Facility Name & ID Number Peterson Park Heath Care Ctr # 0024463 Report Period Beginning: 01/01/20 Ending: 12/31/20

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	1.00	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 Heath Care Ctr # 0024463 Report Period Beginning: 01/01/20 Ending: 12/31/20

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 Heath Care Ctr # 0024463 Report Period Beginning: 01/01/20 Ending: 12/31/20

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	Available Bed Days	2,540,133	53	$ 130,303	$ 130,303	68,808	$ 3,530	1
2	01	Dietary Supplies	Available Bed Days	2,540,133	53	697		68,808	19	2
3	02	Food	Available Bed Days	2,540,133	53	249,220		68,808	6,751	3
4	03	Housekeeping	Available Bed Days	2,540,133	53	84,952		68,808	2,301	4
5	04	Linen Replacement	Available Bed Days	2,540,133	53	5,771		68,808	156	5
6	06	Maintenance Salary	Available Bed Days	2,540,133	53	401,986	401,986	68,808	10,889	6
7	06	Repairs & Maintenance	Available Bed Days	2,540,133	53	23,857		68,808	646	7
8	10	Nursing Salary	Available Bed Days	2,540,133	53	3,327,223	3,327,223	68,808	90,129	8
9	10	Nurse/Medical Director Consulta	Available Bed Days	2,540,133	53	314,035		68,808	8,507	9
10	10	Medical Supplies	Available Bed Days	2,540,133	53	714,824		68,808	19,363	10
11	12	Social Service Salary	Available Bed Days	2,540,133	53	226,662	226,662	68,808	6,140	11
12	11	Activities Program	Available Bed Days	2,540,133	53	335		68,808	9	12
13	12	Social Service Consultant	Available Bed Days	2,540,133	53	893		68,808	24	13
14	17	COO / Administrative Salary	Available Bed Days	2,540,133	53	2,533,078	2,533,078	68,808	68,617	14
15	19	Professional Fees	Available Bed Days	2,540,133	53	831,592		68,808	22,526	15
16	20	Dues / Licenses / Permits	Available Bed Days	2,540,133	53	141,983		68,808	3,846	16
17	21	Clerical & General Wages	Available Bed Days	2,540,133	53	10,220,453	10,220,453	68,808	276,855	17
18	21	Clerical & Office Expense	Available Bed Days	2,540,133	53	745,293		68,808	20,189	18
19	24	Education & Seminars	Available Bed Days	2,540,133	53	5,655		68,808	153	19
20	25	Travel	Available Bed Days	2,540,133	53	189,364		68,808	5,130	20
21	26	Insurance - General	Available Bed Days	2,540,133	53	4,997		68,808	135	21
22	27	Non-Nursing Payroll Taxes / Ben	Available Bed Days	2,540,133	53	1,015,274		68,808	27,502	22
23	34	Rent	Available Bed Days	2,540,133	53	1,281,940		68,808	34,726	23
24	34	Offsite Storage / Parking	Available Bed Days	2,540,133	53	3,949		68,808	107	24
25	TOTALS					$ 22,454,338	$ 16,839,706		$ 608,252	25

Facility Name & ID Number Peterson Park Heath Care Ctr # 0024463 Report Period Beginning: 01/01/20 Ending: 12/31/20

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	Available Bed Days	2,540,133	53	17,109		68,808	463	1
2	35	Auto Rental	Available Bed Days	2,540,133	53	166,843		68,808	4,520	2
3	15	Nursing Payroll Taxes / Benefits	Available Bed Days	2,540,133	53	236,021		68,808	6,393	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					$ 419,973	$		$ 11,376	25

Facility Name & ID Number Peterson Park Heath Care Ctr # 0024463 Report Period Beginning: 01/01/20 Ending: 12/31/20

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	Available Bed Days	2,540,133	53	$ 44,301	$	68,808	$ 1,200	1
2	6	Repairs & Maintenance	Available Bed Days	2,540,133	53	42,932		68,808	1,163	2
3	19	Property Valuation Fee	Available Bed Days	2,540,133	53	15,181		68,808	411	3
4	19	Accounting Fees	Available Bed Days	2,540,133	53	3,453		68,808	94	4
5	20	Dues & Subscriptions	Available Bed Days	2,540,133	53	23		68,808	1	5
6	21	Office Expense	Available Bed Days	2,540,133	53	10,298		68,808	279	6
7	26	Insurance	Available Bed Days	2,540,133	53	11,124		68,808	301	7
8	30	Depreciation	Available Bed Days	2,540,133	53	273,261		68,808	7,402	8
9	32	Interest Expense	Available Bed Days	2,540,133	53	153,558		68,808	4,160	9
10	33	Real Estate Taxes	Available Bed Days	2,540,133	53	139,524		68,808	3,779	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					$ 693,655	$		$ 18,790	25

Facility Name & ID Number Peterson Park Heath Care Ctr # 0024463 Report Period Beginning: 01/01/20 Ending: 12/31/20

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	6	Maintenance	Direct			$	$		$ 31,606	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					$	$		$ 31,606	25

Facility Name & ID Number Peterson Park Heath Care Ctr # 0024463 Report Period Beginning: 01/01/20 Ending: 12/31/20

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 Street, Suite 102
City / State / Zip Code: Skokie, IL
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			$	$		$ 5,763	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					$	$		$ 5,763	25

Facility Name & ID Number Peterson Park Heath Care Ctr # 0024463 Report Period Beginning: 01/01/20 Ending: 12/31/20

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			$	$		$ 29,295	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					$	$		$ 29,295	25

Facility Name & ID Number Peterson Park Heath Care Ctr # 0024463 Report Period Beginning: 01/01/20 Ending: 12/31/20

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 Heath Care Ctr # 0024463 Report Period Beginning: 01/01/20 Ending: 12/31/20

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	Direct			$	$		$ 172,459	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					$	$		$ 172,459	25

Facility Name & ID Number Peterson Park Heath Care Ctr # 0024463 Report Period Beginning: 01/01/20 Ending: 12/31/20

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: Lifescan Labs of Illinois, LLC
Street Address: 5255 Golf Road
City / State / Zip Code: Skokie, IL 60077
Phone Number: (847) 663 - 8300
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	39	Laboratory	Direct			$	$		$ 16,835	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					$	$		$ 16,835	25

Facility Name & ID Number Peterson Park Heath Care Ctr # 0024463 Report Period Beginning: 01/01/20 Ending: 12/31/20

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			$	$ 3,180,274			$ 88,086	1
2												2
3												3
4												4
5												5
	Working Capital											
6	Bank Financial		X	Revolving Line of Credit				757,232			41,090	6
7	Allocated from CF St. Louis		X								4,160	7
8												8
9	TOTAL Facility Related						$	$ 3,937,506			$ 133,335	9
	B. Non-Facility Related*											
10	Interest Income		X								(25,250)	10
11	Interest Income - Building Co.		X								(323)	11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (25,573)	14
15	TOTALS (line 9+line14)						$	$ 3,937,506			$ 107,762	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ 16,615 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 Heath Care Ctr # 0024463 Report Period Beginning: 01/01/20 Ending: 12/31/20

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2019 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 407,668	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.)		$ 398,713	2
3. Under or (over) accrual (line 2 minus line 1).		$ (8,955)	3
4. Real Estate Tax accrual used for 2020 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 414,681	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.)**		$ 811	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.		$ 406,538	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2015	285,486	8
	2016	309,328	9
	2017	326,646	10
	2018	388,255	11
	2019	394,934	12

2020 Accrual = $394,934 x 1.05 = $414,681

Allocated from CF St. Louis: $3,779

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2019	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATIOI	$	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.

2019 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Peterson Park Heath Care Ctr COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0024463

CONTACT PERSON REGARDING THIS REPORT Steven Lavenda

TELEPHONE (847) 282-6330 FAX #: ( )

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

Enter the tax index number and real estate tax assessed for 2019 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 2019.

	(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	$ 394,933.88	$ 394,933.88
2.	10-23-406-034-0000	Home Office Allocation	$ 459,532.44	$ 3,779.47
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 854,466.32	$ 398,713.35

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 copies of the original 2019 tax bills which were listed in Section A to this statement. Be sure to use the 2019 tax bill which is normally paid during 2020.

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: 2019 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 2019 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2019.

Please complete the Real Estate Tax Statement below and include it in the 2020 cost report along with a copy of your 2019 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.

2019 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Peterson Park Heath Care Ctr COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0024463

CONTACT PERSON REGARDING THIS REPORT Steven Lavenda

TELEPHONE ( ) FAX #: ( )

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

Enter the tax index number and real estate tax assessed for 2015 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 2015.

	(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 2015 tax bills which were listed in Section A to this statement. Be sure to use the 2015 tax bill which is normally paid during 2016.

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 Heath Care Ctr # 0024463 Report Period Beginning: 01/01/20 Ending: 12/31/20

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			5,346	2
3	TOTALS			$ 288,417	3

Facility Name & ID Number Peterson Park Heath Care Ctr # 0024463 Report Period Beginning: 01/01/20 Ending: 12/31/20

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	$ 182,431	35	$ 72,824	$ (109,607)	$ 2,478,016	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			1979	4,800		20			4,800	9
10	Various			1981	57,728		20			57,728	10
11	Various			1982	11,967		20			11,967	11
12	Various			1983	3,440		20			3,440	12
13	Various			1984	12,700		20			12,700	13
14	Various			1985	98,707		20			98,707	14
15	Various			1986	42,087		20			42,087	15
16	Various			1987	17,729		20			17,729	16
17	Various			1988	35,577		20			35,577	17
18	Various			1989	14,951		20			14,951	18
19	Various			1990	27,693		20			27,693	19
20	Various			1991	62,352		20			62,352	20
21	Various			1992	10,152		20			10,152	21
22	Various			1993	21,815		20			21,815	22
23	Various			1994	264,384		20			264,384	23
24	Various			1995	103,507		20			103,507	24
25	Various			1996	35,086		20			35,086	25
26	Various			1997	62,950		20			62,950	26
27	Various			1998	49,698		20			49,698	27
28	Various			1999	87,532		20			87,532	28
29	Various			2000	189,224		20	9,422	9,422	189,224	29
30	Various			2001	73,918		20	3,696	3,696	72,770	30
31	Various			2002	350,099		20	17,505	17,505	323,875	31
32	Various			2003	68,436		20	3,912	3,912	56,722	32
33	Various			2004	49,148		20	3,309	3,309	35,938	33
34	Various			2005	49,872		20	2,692	2,692	36,140	34
35	Various			2006	22,247		20	2,530	2,530	4,629	35
36	Various			2007	369,261		20	18,938		239,675	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 Heath Care Ctr # 0024463 Report Period Beginning: 01/01/20 Ending: 12/31/20

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	$ 51,426	37
38	Various	2009	210,789		20	10,539	10,539	120,273	38
39	Various	2010	598,565		20	37,112	37,112	246,872	39
40	Various	2011	201,262		20	11,108	11,108	79,761	40
41	Various	2012	253,137		20	12,657	12,657	84,225	41
42	Various	2013	141,718		20	7,546	7,546	21,435	42
43	Various	2014	298,652		20	14,933	14,933	101,739	43
44	Various	2015	45,507		20	5,036	5,036	(31,157)	44
45	Various	2016	37,011		20	1,851	1,851	7,355	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)		118,630			5,932	5,932	17,795	67
68	Related Party Allocations (Pages 12H & 12I)		251,606	6,824		11,963	5,139	53,521	68
69	Financial Statement Depreciation								69
70	TOTAL (lines 4 thru 69)		$ 7,000,336	$ 189,255		$ 258,607	$ 50,413	$ 5,215,089	70

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

Facility Name & ID Number Peterson Park Heath Care Ctr # 0024463 Report Period Beginning: 01/01/20 Ending: 12/31/20

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		$ 7,000,336	$ 189,255		$ 258,607	$ 69,351	$ 5,215,089	1
2	Frigidaire Wall A/C Units With Electric Heat In	2017			20				2
3	8 Resident Rooms On First Floor South Side	2017	3,825		20	191	191	707	3
4	Separated #1 Ahu And #2 Ahu From The Building,	2017			20				4
5	And Dedicated 1 Hydronic Boiler With Glycol	2017			20				5
6	To Heat Air Handler	2017	14,539		20	727	727	2,688	6
7	Air Handler	2017	102,545		20	5,127	5,127	18,956	7
8	8 New Beds- 2 On First Floor And 6 On Second Floor	2017	503,381		20	25,169	25,169	85,422	8
9	Fire Alarm Tie In To City	2017	9,463		20	473	473	1,433	9
10	Air Handler	2017	59,987		20	2,999	2,999	11,997	10
11	Chiller	2017	97,774		20	4,889	4,889	19,555	11
12	Repaired Steel Pipe For Heating System In Boiler Room ($3632)	2019	3,520		20	176	176	352	12
13	Installed Security Cameras ($5762)	2019	5,584		20	279	279	558	13
14	Testing Infrared System ($2825)	2019	2,738		20	137	137	274	14
15	Repaired Infrared System ($3254.19)	2019	3,154		20	158	158	315	15
16	Installed Parking Lot Fence ($8500)	2019	8,237		20	412	412	824	16
17	Installed Delayed Magnetic Locks On North/South Stair Doors ($6	2019	6,780		20	339	339	678	17
18	Repaired Boiler Gas Valves ($4787.44)	2019	4,640		20	232	232	464	18
19	Installed New Hydraulic Packing For Elevator ($2500)	2019	2,423		20	121	121	242	19
20	Replaced Valve On Kitchen Hot Water Boiler ($2874.83)	2019	2,786		20	139	139	279	20
21	#2 Passenger Elevator - Change Valve On Front Cart ($3,500)	2020	3,414		20	171	171	175	21
22	2 Elevators - Install New Tile, Moldings, Handrails, Panels, Trims (	2020	6,341		20	317	317	317	22
23	Concrete Repair - Spread And Level Concrete Ramp ($2,800)	2020	2,731		20	280	280	280	23
24	#2 Passenger Elevator - Install New Valve Stem Seats ($2,529)	2020	2,467		20	123	123	123	24
25	#1 Passenger Elevator - Replace Packing Seal In Hydraulic Cylinde	2020	3,158		20	158	158	158	25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 7,849,823	$ 189,255		$ 301,224	$ 111,969	$ 5,360,886	34

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

Facility Name & ID Number Peterson Park Heath Care Ctr # 0024463 Report Period Beginning: 01/01/20 Ending: 12/31/20

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		$ 7,849,823	$ 189,255		$ 301,224	$ 111,969	$ 5,360,886	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)		$ 7,849,823	$ 189,255		$ 301,224	$ 111,969	$ 5,360,886	34

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

Facility Name & ID Number Peterson Park Heath Care Ctr # 0024463 Report Period Beginning: 01/01/20 Ending: 12/31/20

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		$ 7,849,823	$ 189,255		$ 301,224	$ 111,969	$ 5,360,886	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)		$ 7,849,823	$ 189,255		$ 301,224	$ 111,969	$ 5,360,886	34

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

Facility Name & ID Number Peterson Park Heath Care Ctr # 0024463 Report Period Beginning: 01/01/20 Ending: 12/31/20

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		$ 7,849,823	$ 189,255		$ 301,224	$ 111,969	$ 5,360,886	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)		$ 7,849,823	$ 189,255		$ 301,224	$ 111,969	$ 5,360,886	34

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

Facility Name & ID Number Peterson Park Heath Care Ctr # 0024463 Report Period Beginning: 01/01/20 Ending: 12/31/20

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	492	9
10	Installed Door & Glass Panels/Drywall/painting in common area	2018	11,015		20	551	551	1,652	10
11	Installed sliding door on 2nd Floor	2018	12,033		20	602	602	1,805	11
12	Repaired backflows in custodial closet and kitchen	2018	9,205		20	460	460	1,381	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	10,710	15
16	Installed egress magnetic lock/fire alarm/cables	2018	2,747		20	137	137	412	16
17	Recreation Room-Install 2 base & 4 wall cabinets, laminate top	2018	2,397		20	120	120	360	17
18	Repaired copper line/concrete slabs by staircase-south end ($7080)	2018	6,553		20	328	328	983	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)		$ 118,630	$		$ 5,932	$ 5,932	$ 17,795	34

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

Facility Name & ID Number Peterson Park Heath Care Ctr # 0024463 Report Period Beginning: 01/01/20 Ending: 12/31/20

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		$ 118,630	$		$ 5,932	$ 5,932	$ 17,795	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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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)		$ 118,630	$		$ 5,932	$ 5,932	$ 17,795	34

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

Facility Name & ID Number Peterson Park Heath Care Ctr # 0024463 Report Period Beginning: 01/01/20 Ending: 12/31/20

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	28,786	1,337	35	822	(514)	4,112	3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Allocated from CF St. Louis, LLC	2016	178,721	4,409	20	8,936	4,527	44,680	9
10	Allocated from CF St. Louis, LLC	2017	4,148	102	20	207	105	830	10
11	Allocated from CF St. Louis, LLC	2019	37,598	928	20	1,880	952	3,760	11
12	Allocated from CF St. Louis, LLC	2019	1,977	49	20	99	50	99	12
13									13
14	Allocated from Legacy HC	2018	214		20	11	11	32	14
15	Allocated from Legacy HC	2020	161		20	8	8	8	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)		$ 251,606	$ 6,824		$ 11,963	$ 5,139	$ 53,521	34

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

Facility Name & ID Number Peterson Park Heath Care Ctr # 0024463 Report Period Beginning: 01/01/20 Ending: 12/31/20

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		$ 251,606	$ 6,824		$ 11,963	$ 5,139	$ 53,521	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
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16									16
17									17
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19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 251,606	$ 6,824		$ 11,963	$ 5,139	$ 53,521	34

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

Facility Name & ID Number Peterson Park Heath Care Ctr # 0024463 Report Period Beginning: 01/01/20 Ending: 12/31/20

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	$ 36,859	$ 576	$ 3,686	$ 3,110	10	$ 13,585	71
72	Current Year Purchases	24,494	2	2,449	2,448	10	2,449	72
73	Fully Depreciated Assets	2,048,901				10	2,048,901	73
74								74
75	TOTALS	$ 2,110,255	$ 578	$ 6,135	$ 5,557		$ 2,064,935	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)	$ 10,248,494	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 189,833	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 307,360	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 117,526	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 7,425,822	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	Architect fees/HVAC	$ 40,764	92
93			93
94			94
95		$ 40,764	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 Heath Care Ctr # 0024463 Report Period Beginning: 01/01/20 Ending: 12/31/20

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				107			5
6								6
7	TOTAL				$ 107 **			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.	/2021	$
13.	/2022	$
14.	/2023	$

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: $ 8,313 Description: See Attached
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Allocated from Legacy HC		$	$ 4,520	17
18					18
19					19
20					20
21	TOTAL		$	$ 4,520	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 Heath Care Ctr # 0024463 Report Period Beginning: 01/01/20 Ending: 12/31/20

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.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39 - 03	hrs	$		$ 325,557	$		$ 325,557	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			123,639			123,639	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			392,415			392,415	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				224,223		224,223	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): See Attached					92,919	187,119		280,038	13
14	TOTAL			$		$ 934,530	$ 411,342		$ 1,345,872	14

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

Facility Name & ID Number Peterson Park Heath Care Ctr # 0024463 Report Period Beginning: 01/01/20 Ending: 12/31/20

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/20 (last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 1,156,902	$ 1,482,538	1
2	Cash-Patient Deposits	6,332	6,332	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	(831,917)	(831,917)	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance		20,015	6
7	Other Prepaid Expenses	175,448	175,448	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Attached	127,944	127,944	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 634,709	$ 980,360	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	34,155	4,745,628	15
16	Equipment, at Historical Cost	37,687	2,319,782	16
17	Accumulated Depreciation (book methods)	72,112	(6,823,100)	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	7,595,126	4,944,796	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 7,739,080	$ 7,838,440	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 8,373,789	$ 8,818,800	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 2,942,679	$ 2,942,680	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	757,232	757,232	29
30	Accrued Salaries Payable	601,592	601,592	30
31	Accrued Taxes Payable (excluding real estate taxes)	359,061	359,061	31
32	Accrued Real Estate Taxes(Sch.IX-B)		414,681	32
33	Accrued Interest Payable		7,023	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached	1,979,315	1,979,315	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 6,639,879	$ 7,061,584	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		3,180,274	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)**	$	$ 3,180,274	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 6,639,879	$ 10,241,858	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,733,910	$ (1,423,058)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 8,373,789	$ 8,818,800	48

***(See instructions.)**

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XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 2,637,993	1
2	Restatements (describe):		2
3	**Prior Year Depreciation**	(58,589)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 2,579,404	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(845,494)	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)**	$ (845,494)	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)**	$ 1,733,910	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	$ 19,243,138	1
2	Discounts and Allowances for all Levels	(8,200,955)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 11,042,183	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,532,610	6
7	Oxygen	656	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 2,533,266	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	203,322	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	51,553	19
20	Radiology and X-Ray	415	20
21	Other Medical Services	37,944	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 293,234	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	25,250	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 25,250	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Attached	1,375,610	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 1,375,610	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 15,269,543	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	2,214,757	31
32	Health Care	6,753,262	32
33	General Administration	4,339,632	33
	B. Capital Expense		
34	Ownership	1,003,836	34
	C. Ancillary Expense		
35	Special Cost Centers	1,347,046	35
36	Provider Participation Fee	456,504	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 16,115,037	40
41	**Income before Income Taxes (line 30 minus line 40)****	(845,494)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (845,494)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 9,377,061	44
45	Private Pay - Net Inpatient Revenue	117,029	45
46	Medicare - Net Inpatient Revenue	1,053,429	46
47	Other-(specify) Insurance	180,580	47
48	Other-(specify) Veterans	314,084	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 11,042,183	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	2,017	2,298	$ 141,931	$ 61.76	1
2	Assistant Director of Nursing	2,100	2,411	113,099	46.91	2
3	Registered Nurses	38,350	45,225	1,623,462	35.90	3
4	Licensed Practical Nurses	32,911	39,673	1,259,780	31.75	4
5	CNAs & Orderlies	79,491	104,123	2,105,183	20.22	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	14,863	16,983	362,531	21.35	8
9	Activity Director	706	1,000	19,902	19.90	9
10	Activity Assistants	9,135	10,350	158,077	15.27	10
11	Social Service Workers	8,144	9,316	288,709	30.99	11
12	Dietician	2,051	2,264	52,181	23.05	12
13	Food Service Supervisor	1,973	2,096	63,358	30.23	13
14	Head Cook	6,450	7,732	149,841	19.38	14
15	Cook Helpers/Assistants	20,418	22,410	341,526	15.24	15
16	Dishwashers					16
17	Maintenance Workers	3,617	4,090	97,580	23.86	17
18	Housekeepers	12,554	14,061	230,464	16.39	18
19	Laundry	4,864	5,590	95,920	17.16	19
20	Administrator	1,968	2,166	100,908	46.59	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	10,541	12,702	263,182	20.72	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	1,832	2,080	47,993	23.07	31
32	Other Health Care(specify)					32
33	Other(specify) See Attached	12,362	14,477	262,035	18.10	33
34	TOTAL (lines 1 - 33)	266,347	321,047	$ 7,777,662 *	$ 24.23	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		$		35
36	Medical Director	Monthly	16,000	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant	Monthly	48,979	10-03	38
39	Pharmacist Consultant	Monthly	5,543	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant	Per Visit	250	10a-03	42
43	Speech Therapy Consultant				43
44	Activity Consultant	Monthly	945	11-03	44
45	Social Service Consultant	Monthly	3,696	12-03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 75,413		49

C. CONTRACT NURSES

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

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Isaac Ninio	Administrator	0	$ 100,908
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 100,908

B. Administrative - Other

Description	Amount
Shabat and Associates	$ 969,000
TOTAL (agree to Schedule V, line 17, col. 3)	$ 969,000
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Marcum LLP	Accounting	$ 24,000
See Attached	Legal	350,386
Propay HR LLC	Payroll Processing	38,001
Legacy Healthcare	Outside Clerical	264,000
Onyx Procurement Solutions	Procurement Services	13,970
Achieve Accreditation	Accreditation	9,191
Compliagent	Compliance	3,662
MTS Consulting	Tax Consulting	961
Personnel Planners	Unemployment Tax Consultant	1,403
Prospect Resources	Energy Procurement	800
Cortex Health Care	Data Processing	10,663
See Supplemental Schedule		8,320
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 725,357

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 123,398
Unemployment Compensation Insurance	31,483
FICA Taxes	594,991
Employee Health Insurance	370,817
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Union Pension	134,627
Other Employee Benefits	18,627
401K Expense	11,993
Voluntary Benefit Contributions	9,019
Employee Physical Exams	10,306
TOTAL (agree to Schedule V, line 22, col.8)	$ 1,305,261

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

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 5,970
Advertising: Employee Recruitment	468
Health Care Worker Background Check	
(Indicate # of checks performed 125)	1,250
Patient Background Checks 93	930
Dues & Subscriptions	33,055
Licenses & Fees	1,097
See Supplemental Schedule	3,847
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 46,616

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	218
See Supplemental Schedule	153
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 371

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Peterson Park Heath Care Ctr # 0024463 Report Period Beginning: 01/01/20 Ending: 12/31/20

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. **HCCI - $30,200, IHCA - $16,072**

(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. $ **38,750** Line **10**

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

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

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

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

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **456,504**
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 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.