

		FOR OFF USE				

LL1

**2005**  
**STATE OF ILLINOIS**  
**DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES**  
**FINANCIAL AND STATISTICAL REPORT FOR**  
**LONG-TERM CARE FACILITIES**  
**(FISCAL YEAR 2005)**

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 Facility ID Number:** 0024463

**Facility Name:** Peterson Park Health Care Center

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

**County:** Cook

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

**IDPA ID Number:** 36-2999153

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

**Type of Ownership:**

<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL
<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State
<input type="checkbox"/> Trust	<input checked="" type="checkbox"/> Partnership	<input type="checkbox"/> County
<b>IRS Exemption Code</b> _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____
	<input type="checkbox"/> "Sub-S" Corp.	
	<input type="checkbox"/> Limited Liability Co.	
	<input type="checkbox"/> Trust	
	<input type="checkbox"/> Other _____	

**In the event there are further questions about this report, please contact:**  
**Name:** Bob Kagda **Telephone Number:** (847)-675-3585

**II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER**

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/05 to 12/31/05 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.

<b>Officer or Administrator of Provider</b>	(Signed) _____	(Date) _____
	(Type or Print Name) _____	
<b>Paid Preparer</b>	(Title) _____	
	(Signed) _____	(Date) _____
<b>Paid Preparer</b>	(Print Name and Title) <u>Bob Kagda Partner</u>	
	(Firm Name & Address) <u>Krupnick, Bokor, Kagda &amp; Brooks, Ltd. 3750 W. Devon Ave. Lincolnwood, IL 60712-1124</u>	
	(Telephone) <u>(847)-675-3585</u>	Fax # <u>(847) 675-5777</u>
	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 Health Care Center

# 0024463 Report Period Beginning: 01/01/05 Ending: 12/31/05

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>93</u>	Skilled (SNF)	<u>93</u>	<u>33,945</u>	1
2		Skilled Pediatric (SNF/PED)			2
3	<u>95</u>	Intermediate (ICF)	<u>95</u>	<u>34,675</u>	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>188</u>	TOTALS	<u>188</u>	<u>68,620</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	<u>6,718</u>	<u>214</u>	<u>4,154</u>	<u>11,086</u>	8
9	SNF/PED					9
10	ICF	<u>48,045</u>	<u>1,814</u>		<u>49,859</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>54,763</u>	<u>2,028</u>	<u>4,154</u>	<u>60,945</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 88.82%

D. How many bed-hold days during this year were paid by the Department? 476 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)  
\_\_\_\_\_

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

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

I. On what date did you start providing long term care at this location?  
Date started 01/01/78

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

K. Was the facility certified for Medicare during the reporting year?  
YES  NO  If YES, enter number of beds certified 17 and days of care provided 4,137

Medicare Intermediary Administar

IV. ACCOUNTING BASIS

ACCRUAL  MODIFIED CASH\*  CASH\*

Is your fiscal year identical to your tax year? YES  NO

Tax Year: 12/31/05 Fiscal Year: 12/31/05

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

Facility Name & ID Number Peterson Park Health Care Center # 0024463 Report Period Beginning: 01/01/05 Ending: 12/31/05

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>A. General Services</b>											
1	Dietary	332,484	49,021	20,270	401,775		401,775		401,775			1
2	Food Purchase		369,242		369,242	(45,070)	324,172	(122)	324,050			2
3	Housekeeping	122,811	26,089		148,900		148,900		148,900			3
4	Laundry	90,037	12,778		102,815		102,815		102,815			4
5	Heat and Other Utilities			183,468	183,468		183,468	7,038	190,506			5
6	Maintenance	108,212		58,080	166,292		166,292	15,757	182,049			6
7	Other (specify):*											7
8	<b>TOTAL General Services</b>	<b>653,544</b>	<b>457,130</b>	<b>261,818</b>	<b>1,372,492</b>	<b>(45,070)</b>	<b>1,327,422</b>	<b>22,673</b>	<b>1,350,095</b>			8
	<b>B. Health Care and Programs</b>											
9	Medical Director			6,000	6,000		6,000		6,000			9
10	Nursing and Medical Records	2,579,417	162,659	55,620	2,797,696		2,797,696		2,797,696			10
10a	Therapy		1,873	13,135	15,008		15,008		15,008			10a
11	Activities	216,669	18,861	27,029	262,559		262,559		262,559			11
12	Social Services	204,997		6,109	211,106		211,106		211,106			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	<b>TOTAL Health Care and Programs</b>	<b>3,001,083</b>	<b>183,393</b>	<b>107,893</b>	<b>3,292,369</b>		<b>3,292,369</b>		<b>3,292,369</b>			16
	<b>C. General Administration</b>											
17	Administrative	161,995		539,645	701,640		701,640	(424,780)	276,860			17
18	Directors Fees											18
19	Professional Services			95,646	95,646		95,646	(34,910)	60,736			19
20	Dues, Fees, Subscriptions & Promotions			55,769	55,769		55,769	(23,998)	31,771			20
21	Clerical & General Office Expenses	123,419	39,189	323,383	485,991		485,991	(39,913)	446,078			21
22	Employee Benefits & Payroll Taxes			620,950	620,950	45,070	666,020	63,441	729,461			22
23	Inservice Training & Education											23
24	Travel and Seminar			3,335	3,335		3,335		3,335			24
25	Other Admin. Staff Transportation			8,404	8,404		8,404	6,394	14,798			25
26	Insurance-Prop.Liab.Malpractice			12,548	12,548		12,548	214,956	227,504			26
27	Other (specify):*							7,599	7,599			27
28	<b>TOTAL General Administration</b>	<b>285,414</b>	<b>39,189</b>	<b>1,659,680</b>	<b>1,984,283</b>	<b>45,070</b>	<b>2,029,353</b>	<b>(231,211)</b>	<b>1,798,142</b>			28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	<b>3,940,041</b>	<b>679,712</b>	<b>2,029,391</b>	<b>6,649,144</b>		<b>6,649,144</b>	<b>(208,538)</b>	<b>6,440,606</b>			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.

Peterson Park Health Care Center  
0024463  
COST REPORT RECLASSIFICATIONS  
01/01/05  
12/31/05

SCHEDULE V  
LINE #

22	EMPLOYEE BENEFITS	45,070
2	FOOD	45,070

To reclass cost of employee meals from raw food to employee benefits

33	REAL ESTATE TAX	
19	PROFESSIONAL FEES	

To reclass cost of appealing real estate taxes

Facility Name & ID Number Peterson Park Health Care Center #0024463 Report Period Beginning: 01/01/05 Ending: 12/31/05

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>D. Ownership</b>											
30	Depreciation							213,702	213,702			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			66,573	66,573		66,573	344,384	410,957			32
33	Real Estate Taxes							236,546	236,546			33
34	Rent-Facility & Grounds			1,122,855	1,122,855		1,122,855	(1,122,855)				34
35	Rent-Equipment & Vehicles			2,648	2,648		2,648		2,648			35
36	Other (specify):* (Mtge Ins & Costs)							75,995	75,995			36
37	<b>TOTAL Ownership</b>			1,192,076	1,192,076		1,192,076	(252,228)	939,848			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers	69,518	182,358	19,500	271,376		271,376		271,376			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			102,930	102,930		102,930		102,930			42
43	Other (specify):*											43
44	<b>TOTAL Special Cost Centers</b>	69,518	182,358	122,430	374,306		374,306		374,306			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	4,009,559	862,070	3,343,897	8,215,526		8,215,526	(460,766)	7,754,760			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 Health Care Center

# 0024463

Report Period Beginning: 01/01/05

Ending: 12/31/05

**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.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	30,024	30		9
10	Interest and Other Investment Income	(57,118)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(122)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(660)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(316)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(248,512)	21		24
25	Fund Raising, Advertising and Promotional	(21,932)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(389)	21		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(53,545)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (352,570)		\$	30

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	2	
		Amount	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)	(108,196)		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ (108,196)		36
37	<b>TOTAL ADJUSTMENTS (A) and (B)</b>	\$ (460,766)		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	2	3	4	
		Yes	No	Amount	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	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	<b>TOTAL (C): (sum of lines 38-46)</b>			\$		47

OHF USE ONLY						
48		49		50		51
						52

Peterson Park Health Care Center

ID# 0024463

Report Period Beginning: 01/01/05

Ending: 12/31/05

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	
1	Deferred Maint Painting & decorating	\$ (1,195)	6	1
2	Deferred Maintenance	198	6	2
3	Ill Council (COPE)	(2,671)	20	3
4	Bank Charges	(3,306)	21	4
5	Adjustments from Peterson Park Realty:			5
6	Bank Charges	(627)	21	6
7	Collection Fees	(42,641)	19	7
8	Myers Miller Duplicate bill	(3,302)	19	8
9				9
10	Depr Round off adj	(1)	30	10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	<b>Total</b>	(53,545)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Peterson Park Health Care Center

# 0024463

Report Period Beginning:

01/01/05

Ending:

12/31/05

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)	
	<b>A. General Services</b>													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(122)	0	0	0	0	0	0	0	0	0	0	(122)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	7,038	0	0	0	0	0	0	0	0	7,038	5
6	Maintenance	(997)	0	16,754	0	0	0	0	0	0	0	0	15,757	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	<b>TOTAL General Services</b>	<b>(1,119)</b>	<b>0</b>	<b>23,792</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>22,673</b>	<b>8</b>
	<b>B. Health Care and Programs</b>													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	<b>TOTAL Health Care and Programs</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative	0	0	(341,645)	(83,135)	0	0	0	0	0	0	0	(424,780)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(46,259)	926	10,423	0	0	0	0	0	0	0	0	(34,910)	19
20	Fees, Subscriptions & Promotions	(25,263)	250	1,015	0	0	0	0	0	0	0	0	(23,998)	20
21	Clerical & General Office Expenses	(252,834)	627	212,294	0	0	0	0	0	0	0	0	(39,913)	21
22	Employee Benefits & Payroll Taxes	0	0	63,441	0	0	0	0	0	0	0	0	63,441	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	6,394	0	0	0	0	0	0	0	0	6,394	25
26	Insurance-Prop.Liab.Malpractice	0	208,550	6,406	0	0	0	0	0	0	0	0	214,956	26
27	Other (specify):*	0	0	0	7,599	0	0	0	0	0	0	0	7,599	27
28	<b>TOTAL General Administration</b>	<b>(324,356)</b>	<b>210,353</b>	<b>(41,672)</b>	<b>(75,536)</b>	<b>0</b>	<b>(231,211)</b>	<b>28</b>						
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	<b>(325,475)</b>	<b>210,353</b>	<b>(17,880)</b>	<b>(75,536)</b>	<b>0</b>	<b>(208,538)</b>	<b>29</b>						

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Peterson Park Health Care Center

# 0024463 Report Period Beginning:

01/01/05 Ending:

12/31/05

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	30,023	167,207	16,472	0	0	0	0	0	0	0	0	213,702	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(57,118)	380,877	20,625	0	0	0	0	0	0	0	0	344,384	32
33	Real Estate Taxes	0	223,771	12,775	0	0	0	0	0	0	0	0	236,546	33
34	Rent-Facility & Grounds	0	(1,122,855)	0	0	0	0	0	0	0	0	0	(1,122,855)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	75,995	0	0	0	0	0	0	0	0	0	75,995	36
37	<b>TOTAL Ownership</b>	<b>(27,095)</b>	<b>(275,005)</b>	<b>49,872</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(252,228)</b>	<b>37</b>
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	<b>TOTAL Special Cost Centers</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>44</b>
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	<b>(352,570)</b>	<b>(64,652)</b>	<b>31,992</b>	<b>(75,536)</b>	<b>0</b>	<b>(460,766)</b>	<b>45</b>						

Facility Name & ID Number Peterson Park Health Care Center

# 0024463

Report Period Beginning:

01/01/05

Ending:

12/31/05

**VII. RELATED PARTIES**

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Schedule attached		Embassy Care Cener	Wilmington			
		Peterson Park Health Care	Chicago			

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V	34 Rent	\$ 1,122,855	Peterson Park Realty		\$	\$ (1,122,855)	1
2	V	32 Interest Expense		Peterson Park Realty		382,953	382,953	2
3	V	20 License and Fees		Peterson Park Realty		250	250	3
4	V	30 Depreciation		Peterson Park Realty		167,207	167,207	4
5	V	21 Bank Charges		Peterson Park Realty		627	627	5
6	V	36 Amort of Mtge Costs		Peterson Park Realty		6,239	6,239	6
7	V	19 Accounting		Peterson Park Realty		926	926	7
8	V	33 RE Tax Expense		Peterson Park Realty		223,771	223,771	8
9	V	26 Insurance		Peterson Park Realty		208,550	208,550	9
10	V	32 Interest Income		Peterson Park Realty		(2,076)	(2,076)	10
11	V	36 Mortgage Insurance		Peterson Park Realty		69,756	69,756	11
12	V							12
13	V							13
14	Total		\$ 1,122,855			\$ 1,058,203	\$ * (64,652)	14

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

Facility Name & ID Number Peterson Park Health Care Center# 0024463Report Period Beginning: 01/01/05Ending: 12/31/05

## VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	17 Management Fees	\$ 539,645	Future Associates		\$	(539,645)	15
16	V	5 Utilities		Future Associates		7,038	7,038	16
17	V	6 Maintenance		Future Associates		16,754	16,754	17
18	V	17 Administrative		Future Associates		198,000	198,000	18
19	V	19 Professional Fees		Future Associates		10,423	10,423	19
20	V	21 Clerical and General	35,112	Future Associates		247,406	212,294	20
21	V	22 Employee Benefits		Future Associates		63,441	63,441	21
22	V	25 Auto Expense		Future Associates		6,394	6,394	22
23	V	26 Insurance Expense		Future Associates		6,406	6,406	23
24	V	30 Depreciation		Future Associates		16,472	16,472	24
25	V	32 Interest Expense		Future Associates		20,625	20,625	25
26	V	33 Real Estate Taxes		Future Associates		12,775	12,775	26
27	V	20 License, Dues, Fees		Future Associates		1,015	1,015	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		\$ 574,757			\$ 606,749	\$ * 31,992	39

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

**VII. RELATED PARTIES (continued)**

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	17 Salary Ron Shabat	\$	Shabat & Associates	100.00%	\$ 114,865	\$ 114,865	15
16	V	27 Payroll Taxes		Shabat & Associates	100.00%	7,599	7,599	16
17	V	17 Management Fees (from Future)	198,000	Future Associates	0.00%		(198,000)	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		\$ 198,000			\$ 122,464	\$ * (75,536)	39

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

Facility Name & ID Number Peterson Park Health Care Center # 0024463 Report Period Beginning: 01/01/05 Ending: 12/31/05

## 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 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Ronald Shabat	Director	Administrative	43.09		25	67.00	Salary	\$ 47,000	17-1	1
2	Ronald Shabat	Director	Administrative	43.09		25	67.00	Allocated	114,865	17-7	2
3	Menachem Shabat	Administrator	Administrative	6.38		60	100.00	Salary	112,690	17-1	3
4	Nachshon Draiman	Director	Administrative	35.64		15	25.00				4
5	Accrual adjustment								2,305		5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 276,860		13

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

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

Facility Name & ID Number Peterson Park Health Care Center

# 0024463

Report Period Beginning:

01/01/05

Ending: 12/31/05

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization Future Associates  
 Street Address 7514 N. Skokie Blvd  
 City / State / Zip Code Skokie, IL  
 Phone Number ( 847)982-1195  
 Fax Number ( 847)982-0992

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	5	Utilities	Management Fees	888,687	2	\$ 11,590	\$ 539,645	\$ 7,038	1
2	6	Maintenance	Management Fees	888,687	2	27,590	539,645	16,754	2
3	17	Administrative	Direct allocation	888,687	2	297,600		198,000	3
4	19	Professional Fees	Management Fees	888,687	2	17,165	539,645	10,423	4
5	21	Clerical and General	Management Fees	888,687	2	353,510	539,645	214,665	5
6	22	Employee Benefits	Management Fees	888,687	2	100,196	539,645	60,843	6
7	25	Auto Expense	Management Fees	888,687	2	10,529	539,645	6,394	7
8	26	Insurance Expense	Management Fees	888,687	2	10,550	539,645	6,406	8
9	30	Depreciation	Management Fees	888,687	2	27,126	539,645	16,472	9
10	32	Interest Expense	Management Fees	888,687	2	33,966	539,645	20,625	10
11	33	Real Estate Taxes	Management Fees	888,687	2	21,038	539,645	12,775	11
12	20	License, Dues, Fees	Management Fees	888,687	2	1,672	539,645	1,015	12
13	21	Clerical and General	Per cent	100	2	50,371	65	32,741	13
14	22	Employee Benefits	Per cent	100	2	3,997	65	2,598	14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 966,900	\$	\$ 606,749	25

Facility Name & ID Number Peterson Park Health Care Center

# 0024463

Report Period Beginning: 01/01/05

Ending: 12/31/05

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization Shabat & Associates  
 Street Address 7514 N Skokie Blvd  
 City / State / Zip Code Chicago, IL 60077  
 Phone Number ( 847)-982-1195  
 Fax Number ( 847)982-0992

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	17	Salary R Shabat	Avg Hrs Wkd	37	3	\$ 170,000	\$ 170,000	25	\$ 114,865	1
2	27	Payroll Taxes	Avg Hrs Wkd	37	3	11,247		25	7,599	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					\$ 181,247	\$ 170,000		\$ 122,464	25

**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**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
											YES	NO				Original	Balance			
<b>A. Directly Facility Related</b>																				
<b>Long-Term</b>																				
1	Heartland Bank		X	Mortgage	\$39,040.46	10/16/04	\$ 6,296,100	\$ 6,166,961	11/01/29	5.6000	\$ 377,784	1								
2												2								
3	BankFinancial, F.S.B.		x								759	3								
4												4								
5												5								
<b>Working Capital</b>																				
6	BankFinancial, F.S.B.		X	Line of Credit			1,000,000	1,000,000			57,117	6								
7	Insurance		X								4,409	7								
8	Illinois Provider Asses		X								10,292	8								
9	<b>TOTAL Facility Related</b>				\$39,040.46		\$ 7,296,100	\$ 7,166,961			\$ 450,361	9								
<b>B. Non-Facility Related*</b>																				
10	Interest Income (Realty)	X									(2,076)	10								
11	Interest Income	X									(57,118)	11								
12	IRS		X								(835)	12								
13	Allocation from Future										20,625	13								
14	<b>TOTAL Non-Facility Related</b>						\$	\$			\$ (39,404)	14								
15	<b>TOTALS (line 9+line14)</b>						\$ 7,296,100	\$ 7,166,961			\$ 410,957	15								

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 69,756 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.)

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

**B. Real Estate Taxes**

<p><b>Important</b>, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.</p>																																				
1. Real Estate Tax accrual used on 2004 report.		\$ <b>220,000</b>	<b>1</b>																																	
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.)		\$ <b>234,546</b>	<b>2</b>																																	
3. Under or (over) accrual (line 2 minus line 1).		\$ <b>14,546</b>	<b>3</b>																																	
4. Real Estate Tax accrual used for 2005 report. (Detail and explain your calculation of this accrual on the lines below.)		\$ <b>222,000</b>	<b>4</b>																																	
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. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>		\$	<b>5</b>																																	
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. <b>TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>		\$	<b>6</b>																																	
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$ <b>236,546</b>	<b>7</b>																																	
Real Estate Tax History:																																				
Real Estate Tax Bill for Calendar Year:	<table border="1"> <tr><td>2000</td><td><b>223,731</b></td><td><b>8</b></td></tr> <tr><td>2001</td><td><b>229,549</b></td><td><b>9</b></td></tr> <tr><td>2002</td><td><b>232,123</b></td><td><b>10</b></td></tr> <tr><td>2003</td><td><b>216,952</b></td><td><b>11</b></td></tr> <tr><td>2004</td><td><b>221,771</b></td><td><b>12</b></td></tr> </table>	2000	<b>223,731</b>	<b>8</b>	2001	<b>229,549</b>	<b>9</b>	2002	<b>232,123</b>	<b>10</b>	2003	<b>216,952</b>	<b>11</b>	2004	<b>221,771</b>	<b>12</b>	<table border="1"> <tr><td colspan="2"><b>FOR OHF USE ONLY</b></td><td></td></tr> <tr><td><b>13</b></td><td>FROM R. E. TAX STATEMENT FOR 2004</td><td>\$</td><td><b>13</b></td></tr> <tr><td><b>14</b></td><td>PLUS APPEAL COST FROM LINE 5</td><td>\$</td><td><b>14</b></td></tr> <tr><td><b>15</b></td><td>LESS REFUND FROM LINE 6</td><td>\$</td><td><b>15</b></td></tr> <tr><td><b>16</b></td><td>AMOUNT TO USE FOR RATE CALCULATION</td><td>\$</td><td><b>16</b></td></tr> </table>	<b>FOR OHF USE ONLY</b>			<b>13</b>	FROM R. E. TAX STATEMENT FOR 2004	\$	<b>13</b>	<b>14</b>	PLUS APPEAL COST FROM LINE 5	\$	<b>14</b>	<b>15</b>	LESS REFUND FROM LINE 6	\$	<b>15</b>	<b>16</b>	AMOUNT TO USE FOR RATE CALCULATION	\$	<b>16</b>
2000	<b>223,731</b>	<b>8</b>																																		
2001	<b>229,549</b>	<b>9</b>																																		
2002	<b>232,123</b>	<b>10</b>																																		
2003	<b>216,952</b>	<b>11</b>																																		
2004	<b>221,771</b>	<b>12</b>																																		
<b>FOR OHF USE ONLY</b>																																				
<b>13</b>	FROM R. E. TAX STATEMENT FOR 2004	\$	<b>13</b>																																	
<b>14</b>	PLUS APPEAL COST FROM LINE 5	\$	<b>14</b>																																	
<b>15</b>	LESS REFUND FROM LINE 6	\$	<b>15</b>																																	
<b>16</b>	AMOUNT TO USE FOR RATE CALCULATION	\$	<b>16</b>																																	
<b>Estimate based on 2004 bill</b>	<b>222000</b>																																			
<b>Allocation from Future</b>	<b>12775</b>																																			

**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.**

**IMPORTANT NOTICE**

**TO:** Long Term Care Facilities with Real Estate Tax Rates **RE:** 2004 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 2004 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2004.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2004 real estate tax bill to the Department of Public Aid, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

**Please send these items in with your completed 2005 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed.** If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

**2004 LONG TERM CARE REAL ESTATE TAX STATEMENT**

FACILITY NAME Peterson Park Health Care Center COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0024463

CONTACT PERSON REGARDING THIS REPORT \_\_\_\_\_

TELEPHONE ( ) \_\_\_\_\_ FAX #: ( ) \_\_\_\_\_

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

Enter the tax index number and real estate tax assessed for 2004 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 2004.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>13-02-115-052-0000</u>	<u>Facility</u>	\$ <u>221,771.00</u>	\$ <u>221,771.00</u>
2. <u>10-28-408-025</u>	<u>Management Office</u>	\$ <u>16,325.10</u>	\$ <u>2,816.00</u>
3. <u>10-28-408-026</u>	<u>Management Office</u>	\$ <u>7,929.28</u>	\$ <u>1,368.00</u>
4. <u>10-28-408-027</u>	<u>Management Office</u>	\$ <u>7,929.28</u>	\$ <u>1,368.00</u>
5. <u>10-28-408-028</u>	<u>Management Office</u>	\$ <u>16,346.17</u>	\$ <u>2,820.00</u>
6. <u>10-28-408-029</u>	<u>Management Office</u>	\$ <u>16,346.17</u>	\$ <u>2,820.00</u>
7. <u>10-28-408-030</u>	<u>Management Office</u>	\$ <u>1,723.00</u>	\$ <u>297.00</u>
8. <u>10-28-408-031</u>	<u>Management Office</u>	\$ <u>1,723.00</u>	\$ <u>297.00</u>
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
	<b>TOTALS</b>	\$ <u>290,093.00</u>	\$ <u>233,557.00</u>

**B. Real Estate Tax Cost Allocations**

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

If YES, attach an explanation & 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 2004 tax bills which were listed in Section A to this statement. Be sure to use the 2004 tax bill which is normally paid during 2005.

Facility Name & ID Number Peterson Park Health Care Center

# 0024463 Report Period Beginning:

01/01/05 Ending:

12/31/05

**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  (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?  (a) Own the Equipment  (b) Rent equipment from a Related Organization.  (c) Rent equipment from Completely Unrelated Organization.

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

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

---

---

---

---

---

---

---

---

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?  YES  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	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>Facility</u>		<u>1986</u>	<u>\$ 283,071</u>	1
2					2
3	<b>TOTALS</b>			<b>\$ 283,071</b>	3

Facility Name &amp; ID Number Peterson Park Health Care Center

# 0024463

Report Period Beginning:

01/01/05

Ending:

12/31/05

**XI. OWNERSHIP COSTS (continued)****B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	188		1986		\$ 2,548,850	\$ 94,305	35	\$ 72,824	\$ (21,481)	\$ 1,389,726	4
5	Alloc LCF		1986		131,976	5,279	Var	4,399	(880)	83,951	5
6	Alloc LCF		1987		3,166	101	31.5	101		1,861	6
7											7
8											8
	<b>Improvement Type**</b>										
9	Various		1979		4,800					4,800	9
10	Various		1981		57,728					57,728	10
11	Various		1982		11,967					11,967	11
12	Various		1983		3,440					3,440	12
13	Various		1984		12,700					12,700	13
14	Various		1985		98,707		Var			98,707	14
15	Various		1986		42,087	15	19	988	973	42,087	15
16	Various		1987		17,729	563	31	572	9	10,730	16
17	Various		1988		35,577	1,130	31	1,148	18	19,880	17
18	Various		1989		14,591	463	31	471	8	7,709	18
19	Various		1990		27,693	880	31	893	13	13,755	19
20	Various		1991		62,352	1,979	20	3,117	1,138	44,462	20
21	Various		1992		10,152	322	20	507	185	7,110	21
22	Various		1993		21,815	245	20	1,089	844	13,763	22
23	Various		1994		264,384	5,869	20	13,212	7,343	148,872	23
24	Various		1995		103,507	2,750	20	5,176	2,426	54,107	24
25	Various		1996		35,086	955	20	1,752	797	16,795	25
26	Various		1997		62,950	1,614	20	3,145	1,531	26,450	26
27	Various		1998		49,698	1,274	20	2,485	1,211	19,189	27
28	Various		1999		87,532	2,480	20	4,371	1,891	29,881	28
29	Various		2000		188,443	4,827	20	9,418	4,591	52,076	29
30	Various		2001		73,918	1,894	20	3,695	1,801	17,282	30
31	Electric line and outlets		1/16/02		3,380	87	20	169	82	591	31
32	Nurse call system		2/15/02		767	19	20	38	19	134	32
33	Solenoid lock w/ magnet		2/15/02		885	23	20	44	21	155	33
34	Nurs call system 2 south		3/25/02		728	19	20	36	17	127	34
35	Nurs call system 1 north		3/25/02		741	19	20	37	18	130	35
36	Remove old ceiling		5/8/02		82,615	2118	20	4131	2,013	14,458	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 &amp; ID Number Peterson Park Health Care Center

# 0024463

Report Period Beginning:

01/01/05

Ending:

12/31/05

**XI. OWNERSHIP COSTS (continued)****B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	Exhaust Fan	5/13/02	\$ 1,875	\$ 48	20	\$ 94	\$ 46	\$ 328	37
38	7 Air conditioners	5/13/02	4,485	115	20	224	109	785	38
39	Exhaust Fan	5/14/02	3,865	99	20	193	94	676	39
40	Plastic anchors	5/28/02	1,098	28	20	55	27	192	40
41	Nurse station	5/30/02	53,692	1,377	20	2,684	1,307	9,396	41
42	New stainless steel sink	6/3/02	540	14	20	27	13	94	42
43	New crown moldings dayrooms	6/3/02	4,170	107	20	209	102	730	43
44	Remove install handrail bumpers	6/12/02	6,060	155	20	303	148	1,060	44
45	Repair 2 broken floor drains	6/12/02	550	14	20	27	13	96	45
46	Window and new light	6/14/02	808	20	20	40	20	141	46
47	Remove install floor d/r	6/17/02	22,784	584	20	1,139	555	3,987	47
48	Front door alarm	6/19/02	1,114	28	20	56	28	195	48
49	Wall covering	6/20/02	55,100	1,413	20	2,755	1,342	9,642	49
50	Remove and install d/r lighting	6/20/02	43,005	1,102	20	2,150	1,048	7,526	50
51	Paint remove walls paint wall coverings	6/20/02	1,488	38	20	74	36	260	51
52	Modified bitumen roof install	7/2/02	1,100	29	20	55	26	193	52
53	Handrails, bumpers & soffits	7/12/02	9,031	232	20	451	219	1,580	53
54	Room signage, end caps window trimnt	8/2/02	5,023	129	20	251	122	879	54
55	Install 8inch+D29 inline duct fan	8/9/02	875	23	20	44	21	153	55
56	PA System	8/12/02	2,939	75	20	147	72	514	56
57	Architect per retainer	8/31/02	3,000	77	20	150	73	525	57
58	Architect -Remodeling and addition	9/8/02	970	25	20	49	24	170	58
59	Modified bitumen roof install	9/20/02	1,480	38	20	74	36	259	59
60	Paint Moldings	9/27/02	700	18	20	35	17	123	60
61	Install security hardware	10/2/02	545	14	20	27	13	95	61
62	CCTV System 1 north day room	10/28/02	1,037	26	20	52	26	182	62
63	CCTV System 1 south D/R	10/28/02	1,037	26	20	52	26	182	63
64	Install latching alarm system	10/28/02	1,266	32	20	63	31	221	64
65	Rebuild And clean bathroom exhaust fans	10/31/02	1,225	32	20	61	29	214	65
66	2 new firex smoke alarms/detectors	11/13/02	1,755	45	20	88	43	307	66
67	CCTV System 2nd Floor South D/R	12/10/02	1,137	29	20	57	28	199	67
68	CCTV System 2nd Floor North D/R	12/10/02	1,137	29	20	57	28	199	68
69	Ceramic wall tile	12/11/02	4,801	123	20	240	117	840	69
70	TOTAL (lines 4 thru 69)		\$ 4,299,656	\$ 135,374		\$ 145,801	\$ 10,427	\$ 2,246,566	70

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

Facility Name &amp; ID Number Peterson Park Health Care Center

# 0024463

Report Period Beginning:

01/01/05

Ending:

12/31/05

**XI. OWNERSHIP COSTS (continued)****B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	<b>Totals from Page 12A, Carried Forward</b>		\$ 4,299,656	\$ 135,374		\$ 145,801	\$ 10,427	\$ 2,246,566	1
2	Fire rated exit device	12/11/02	4,281	110	20	214	104	749	2
3	Window treatments	12/20/02	10,010	257	20	501	244	1,752	3
4	15 bathroom remodeling	12/23/02	7,000	180	20	350	170	1,225	4
5	Heat & A/C Motor	01/02/03	1,274	33	20	63	30	159	5
6	New fan, 26 blade''	01/02/03	652	16	20	33	17	82	6
7	New smoke detector assembly	01/26/03	865	23	20	43	20	108	7
8	Bathroom remodeling	01/29/03	4,595	118	20	229	111	574	8
9	Roof repairs	02/03/03	715	19	20	35	16	89	9
10	Installed CCTV for lobby	02/07/03	1,447	37	20	72	35	181	10
11	Three compmnt. sink w/drains	02/07/03	950	24	20	48	24	119	11
12	Install CCTV main dining room	02/07/03	1,237	32	20	62	30	155	12
13	Two pipe freezing unit	02/11/03	946	25	20	47	22	118	13
14	B7G motor assembly	02/17/03	2,360	61	20	118	57	295	14
15	Recirculating pump on storage tank	02/21/03	750	19	20	38	19	94	15
16	Nurses call system	03/01/03	765	20	20	39	19	96	16
17	Install CCTV o/s delivery door	03/28/03	1,286	33	20	65	32	161	17
18	Install CCTV basement	03/28/03	1,382	36	20	69	33	173	18
19	Roof repairs	04/10/03	660	17	20	33	16	83	19
20	Defrost clock walk in freezer	04/16/03	573	15	20	29	14	72	20
21	Leak in baseboard	04/29/03	1,161	30	20	58	28	145	21
22	Cedar fencing	05/08/03	2,800	71	20	140	69	350	22
23	Nurses station 2nd floor	05/16/03	550	14	20	28	14	69	23
24	Stockade fencing	06/04/03	1,880	49	20	94	45	235	24
25	Elevator communication system	06/12/03	887	23	20	44	21	111	25
26	Electrical svce basement, cctv panel	06/12/03	532	14	20	26	12	66	26
27	Electrical svce in kitchen	06/12/03	813	21	20	41	20	102	27
28	Telephone svce, outlets, lines	06/12/03	716	19	20	36	17	90	28
29	Montiring system for CCTV	06/12/03	1,044	27	20	52	25	130	29
30	Elevator repairs	06/30/03	10,591	271	20	530	259	1,324	30
31	Verical sewerage pump	07/11/03	5,813	149	20	291	142	727	31
32	Patio door	07/29/03	5,774	148	20	289	141	722	32
33	Circuit breakers elect svce	08/25/03	942	24	20	47	23	118	33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 4,374,907	\$ 137,309		\$ 149,565	\$ 12,256	\$ 2,257,040	34

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

Facility Name &amp; ID Number Peterson Park Health Care Center

# 0024463

Report Period Beginning:

01/01/05

Ending:

12/31/05

**XI. OWNERSHIP COSTS (continued)****B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	<b>Totals from Page 12B, Carried Forward</b>		\$ 4,374,907	\$ 137,309		\$ 149,565	\$ 12,256	\$ 2,257,040	1
2	Nurses call system 2nd floor	8/25/03	817	21	20	40	19	112	2
3	B&G circulating pump	8/25/03	3,845	98	20	193	95	481	3
4	Parking lot repaving	9/12/03	5,100	131	20	255	124	638	4
5	Pump motor	9/12/03	829	22	20	42	20	104	5
6	Johnson controls	10/21/03	1,146	29	20	57	28	143	6
7	Walk in cooler leaks & short cycles	10/29/03	941	24	20	47	23	118	7
8	Telephone svce, in basement	11/28/03	800	21	20	40	19	100	8
9	Duct control panel	12/30/03	10,800	277	20	540	263	1,350	9
10	Front door locking system	1/7/04	716	18	20	36	18	54	10
11	2nd floor nurse call system	1/7/04	685	17	20	34	17	51	11
12	2nd floor electrical problem	1/7/04	683	17	20	34	17	51	12
13	CCTV service	1/7/04	1,151	30	20	57	27	86	13
14	Fire dampers actuators	1/15/04	1,424	37	20	71	34	107	14
15	Telephone system	2/29/04	10,557	271	20	528	257	792	15
16	Design service	2/29/04	13,045	334	20	652	318	978	16
17	Install latching alarm system	3/15/04	1,137	29	20	57	28	85	17
18	Electrical outlets, wall mounts	3/15/04	688	18	20	35	17	52	18
19	Install wall mount, call button & display	3/15/04	738	19	20	37	18	55	19
20	Digital recorder for CCTV	3/22/04	1,544	40	20	77	37	116	20
21	Floor drains	4/12/04	1,074	27	20	54	27	81	21
22	Tele svce in basement	5/5/04	1,275	33	20	64	31	96	22
23	Remove shower base, reinforce walls	5/23/04	2,200	57	20	110	53	165	23
24	Remove shower base, reinforce walls	5/23/04	2,200	57	20	110	53	165	24
25	Tile work 4 bathrooms	5/28/04	4,525	116	20	226	110	339	25
26	Video monitoring system	6/29/04	1,590	41	20	79	38	119	26
27	Electrical outlets, circuit breakers	6/29/04	942	24	20	47	23	71	27
28	12 A/C units	6/30/04	6,262	161	20	313	152	470	28
29	Install 220 volt outlet kitchen	6/30/04	553	14	20	28	14	42	29
30	New toilet	7/28/04	650	16	20	33	17	49	30
31	Elec service kitchen	8/20/04	575	14	20	29	15	43	31
32	Elec service 1st floor	8/31/04	542	14	20	27	13	41	32
33	Review alarm system	9/22/04	893	23	20	45	22	67	33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 4,454,834	\$ 139,359		\$ 153,562	\$ 14,203	\$ 2,264,261	34

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

Facility Name &amp; ID Number Peterson Park Health Care Center

# 0024463

Report Period Beginning:

01/01/05

Ending:

12/31/05

**XI. OWNERSHIP COSTS (continued)****B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	<b>Totals from Page 12C, Carried Forward</b>		\$ 4,454,834	\$ 139,359		\$ 153,562	\$ 14,203	\$ 2,264,261	1
2	Doors	09/24/04	651	17	20	33	16	49	2
3	Route drain lines, new faucets	09/26/04	1,080	28	20	54	26	81	3
4	Cement sidewalk	09/27/04	1,000	26	20	50	24	75	4
5	Rerun return electric cables	10/22/04	699	18	20	35	17	52	5
6	Repair 4 drainpipe"	11/20/04	630	16	20	31	15	47	6
7	Drain Lines, pipe fittings	11/30/04	920	24	20	46	22	69	7
8	Roof repairs	11/30/04	850	22	20	43	21	64	8
9	Drain line outside bldg	12/19/04	2,600	66	20	130	64	195	9
10	Install 220 amp outlet	12/27/04	942	24	20	47	23	71	10
11	Public address sound system	12/30/04	1,151	30	20	57	27	86	11
12	Cable to office; install speaker kit	01/07/05	786	19	20	20	1	20	12
13	Rear door alarm	01/07/05	670	16	20	17	1	17	13
14	Ceiling mounted tracks	01/17/05	1,047	26	20	26		26	14
15	Pump motor & flame contol	01/27/05	4,362	107	20	109	2	109	15
16	Install pump in pit	02/10/05	2,906	65	20	73	8	73	16
17	Nurses call system	03/01/05	669	14	20	17	3	17	17
18	Electric service in basement	03/01/05	808	16	20	20	4	20	18
19	New awning	03/14/05	2,100	43	20	53	10	53	19
20	Replace copper pipe	03/31/05	720	15	20	18	3	18	20
21	Kitchen ceiling light lines;on off switches	04/14/05	1,042	19	20	26	7	26	21
22	Update north nurse call station	05/02/05	654	10	20	16	6	16	22
23	Electric service 2nd floor north	05/02/05	742	12	20	19	7	19	23
24	Monitoring system to rear pkg lot	06/01/05	1,398	19	20	35	16	35	24
25	Installation of exterior insulation	06/15/05	4,000	56	20	100	44	100	25
26	Electric service 2nd floor end rooms	07/05/05	732	9	20	18	9	18	26
27	New fence	07/14/05	14,000	165	20	32	(133)	32	27
28	Roof caulk.membrane & rubberized coat	08/01/05	1,250	12	20	31	19	31	28
29	6 A/C	08/08/05	2,936	28	20	73	45	73	29
30	Lobby & conference room carpeting	08/08/05	3,301	32	20	83	51	83	30
31	Door monitoring system	09/12/05	4,870	36	20	122	86	122	31
32	Electric service 1st floor south	09/28/05	929	7	20	23	16	23	32
33	Rebuilt new blower assembly	10/21/05	3,243	17	20	81	64	81	33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 4,518,522	\$ 140,373		\$ 155,100	\$ 14,727	\$ 2,266,062	34

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

Facility Name & ID Number Peterson Park Health Care Center

# 0024463

Report Period Beginning:

01/01/05

Ending:

12/31/05

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		\$ 4,518,522	\$ 140,373		\$ 155,100	\$ 14,727	\$ 2,266,062	1
2	Nurses call system 2 south	10/26/2005	676	4	20	17	13	17	2
3									3
4	Alloc from LCF	1987	18,164	577	31.5	577		10,522	4
5	Alloc from LCF	1988	1,020	32	31.5	32		561	5
6	Alloc from LCF	1989	380	12	31.5	12		196	6
7	Alloc from LCF	1993	10,550	270	39	270		3,345	7
8	Alloc from LCF	1994	16,088	412	39	412		4,724	8
9	Alloc from LCF	2001	4,480	115	39	115		515	9
10	Alloc from LCF-5 Ton Trane A/C	2002	1,098	28	39	28		95	10
11	Alloc from LCF-Office Remodeling	2003	667	17	39	17		33	11
12	Alloc from LCF-Electrical	2004	2,309	64	39	64		116	12
13	Alloc from LCF-Roof	2004	299	Columns 5 to 9 included on line 12					13
14	Alloc from Future Associates	1987	57,243	1,817	31.5	1,847	30	34,874	14
15	Alloc from Future Associates	1994	16,742	227	Var	227		10,497	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)		\$ 4,648,238	\$ 143,948		\$ 158,718	\$ 14,770	\$ 2,331,557	34

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

Facility Name & ID Number Peterson Park Health Care Center # 0024463 Report Period Beginning: 01/01/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 454,243	\$ 32,920	\$ 47,007	\$ 14,087	10	\$ 283,151	71
72	Current Year Purchases	21,481	3,810	978	(2,832)	10	978	72
73	Fully Depreciated Assets	743,138	383	4,382	3,999	5-10	743,138	73
74								74
75	TOTALS	\$ 1,218,862	\$ 37,113	\$ 52,367	\$ 15,254		\$ 1,027,267	75

D. Vehicle Depreciation (See instructions.)\*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				\$	\$	\$	\$		\$	76
77	Allocation from Future			140,107	2,617	2,617		5	83,066	77
78										78
79										79
80	TOTALS			\$ 140,107	\$ 2,617	\$ 2,617	\$		\$ 83,066	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)		\$ 6,290,278	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)		\$ 183,678	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)		\$ 213,702	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)		\$ 30,024	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)		\$ 3,441,890	85

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

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

G. Construction-in-Progress

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

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

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

**XII. RENTAL COSTS**

**A. Building and Fixed Equipment (See instructions.)**

1. Name of Party Holding Lease: \_\_\_\_\_

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? \_\_\_\_\_

If NO, see instructions.

YES  NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$ _____			3
4	Additions				_____			4
5					_____			5
6					_____			6
7	<b>TOTAL</b>				\$ _____			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.	_____ /2006	\$ _____
13.	_____ /2007	\$ _____
14.	_____ /2008	\$ _____

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: \$ 2,648 Description: Postage 1370; Scale 975; Halls Rental 303

(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			\$ _____	\$ _____	17
18			_____	_____	18
19			_____	_____	19
20			_____	_____	20
21	<b>TOTAL</b>		\$ _____	\$ _____	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.

**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.)**

<p><b>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?</b></p> <p><input type="checkbox"/> YES      <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p><b>2. CLASSROOM PORTION:</b></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p><b>3. CLINICAL PORTION:</b></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
---	---	--

**B. EXPENSES**

**ALLOCATION OF COSTS (d)**

		Facility		3	4
		1	2		
		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	<b>TOTALS</b>	\$	\$	\$	\$
10	<b>SUM OF line 9, col. 1 and 2 (e)</b>	\$			

**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)	
<b>TOTAL TRAINED</b>	

- (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.

Facility Name &amp; ID Number Peterson Park Health Care Center

# 0024463

Report Period Beginning:

01/01/05

Ending:

12/31/05

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

	Service	1 Schedule V Line & Column Reference	2 Staff		3 Cost		4 Outside Practitioner (other than consultant)		5 Supplies (Actual or Allocated)	6 Total Units (Column 2 + 4)	7 Total Cost (Col. 3 + 5 + 6)	8
			Units of Service	Cost	Units	Cost						
1	Licensed Occupational Therapist		hrs	\$		\$		\$				1
2	Licensed Speech and Language Development Therapist		hrs									2
3	Licensed Recreational Therapist		hrs									3
4	Licensed Physical Therapist	39-3	1898 hrs	69,518						1,898	69,518	4
5	Physician Care		visits									5
6	Dental Care		visits									6
7	Work Related Program		hrs									7
8	Habilitation		hrs									8
9	Pharmacy	39-2	# of prescrpts					143,860			143,860	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs									10
11	Academic Education		hrs									11
12	Exceptional Care Program											12
13	Other (specify): Schedule	39-2;39-3				19,216		38,782			57,998	13
14	TOTAL			\$ 69,518		\$ 19,216		\$ 182,642		1,898	\$ 271,376	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.

Peterson Park Health Care Center

0024463

01/01/05 to

12/31/05

Page16 Supplemnt

Special Services - Supplies - (Column 6 -Other)

1 Med Tube : Ent., & Urol	39-2	9562
2 Equipment Rental	39-2	28936
Medicare - Other	39-2	284
Total		<u>38782</u>

Outside Therapies (Column 5- Other)

1 Respiratory Therapy	39-3	10055
2 Lab & XRay	39-3	9161
Total		<u>19216</u>

Facility Name & ID Number Peterson Park Health Care Center# 0024463Report Period Beginning: 01/01/05

Ending:

12/31/05

## XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/05

(last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 250	\$ 1,727	1
2	Cash-Patient Deposits	84,043	84,043	2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance )	1,780,634	1,780,805	3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	13,670	189,631	6
7	Other Prepaid Expenses		3,431	7
8	Accounts Receivable (owners or related parties)	70,413	4,870,095	8
9	Other(specify): <u>Schedule</u>	1,635	578,402	9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 1,950,645	\$ 7,508,134	10
	<b>B. Long-Term Assets</b>			
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		1,693,444	15
16	Equipment, at Historical Cost		1,239,521	16
17	Accumulated Depreciation (book methods)		(4,157,278)	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): <u>Schedule</u>		180,342	23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$	\$ 1,607,363	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 1,950,645	\$ 9,115,497	25

		1 Operating	2 After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 726,306	\$ 836,997	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	81,661	81,661	28
29	Short-Term Notes Payable	1,000,000	1,000,000	29
30	Accrued Salaries Payable	600,705	600,705	30
31	Accrued Taxes Payable (excluding real estate taxes)	273,421	273,421	31
32	Accrued Real Estate Taxes(Sch.IX-B)		222,000	32
33	Accrued Interest Payable		28,779	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36	<u>Schedule</u>			36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 2,682,093	\$ 3,043,563	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable			39
40	Mortgage Payable		6,166,961	40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43	<u>Schedule</u>			43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$	\$ 6,166,961	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 2,682,093	\$ 9,210,524	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ (731,448)	\$ (95,027)	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 1,950,645	\$ 9,115,497	48

\*(See instructions.)

OTHER CURRENT ASSETS:	<u>Amount</u>	<u>Amount</u>
Real Estate Tax Escrow		120,195
Employee Advances	1,635	1,635
Insurance Escrows		24,354
Replacement & Repairs Escrows		432,218

	<u>1,635</u>	<u>578,402</u>
--	--------------	----------------

OTHER NON CURRENT ASSETS:

Construction In Progress		
Utility Deposit		
Mortgage Costs - Net		180,342
Exchange		

	<u>180,342</u>	
--	----------------	--

OTHER CURRENT LIABILITIES:	<u>Amount</u>	<u>Amount</u>
Accrued Expenses		

	<u></u>	<u></u>
--	---------	---------

OTHER NON CURRENT LIABILITIES:

	<u></u>	<u></u>
--	---------	---------

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (415,631)	1
2	Restatements (describe):		2
3	Round off adj	(1)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (415,632)	6
<b>A. Additions (deductions):</b>			
7	NET Income (Loss) (from page 19, line 43)	(259,416)	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	(56,400)	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)	\$ (315,816)	17
<b>B. Transfers (Itemize):</b>			
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)	\$ (731,448)	24 *

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

Facility Name & ID Number Peterson Park Health Care Center# 0024463Report Period Beginning: 01/01/05Ending: 12/31/05**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.**

		1	
Revenue		Amount	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 7,887,403	1
2	Discounts and Allowances for all Levels	(392,382)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	<b>\$ 7,495,021</b>	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	269,947	6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	<b>\$ 269,947</b>	8
<b>C. Other Operating Revenue</b>			
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	153,904	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	18,104	20
21	Other Medical Services	59,451	21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	<b>\$ 231,459</b>	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	57,118	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	<b>\$ 57,118</b>	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<u>Adj of Prior Period Expenses</u>	(97,435)	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	<b>\$ (97,435)</b>	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	<b>\$ 7,956,110</b>	30

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	1,372,492	31
32	Health Care	3,292,369	32
33	General Administration	1,984,283	33
<b>B. Capital Expense</b>			
34	Ownership	1,192,076	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	271,376	35
36	Provider Participation Fee	102,930	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	<b>\$ 8,215,526</b>	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	<b>(259,416)</b>	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	<b>\$ (259,416)</b>	43

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

\*\* Does this agree with taxable income (loss) per Federal Income Tax Return? \_\_\_\_\_ 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.

SUPPLEMENTAL SCHEDULE OF REVENUES  
12/31/05

DESCRIPTION AMOUNT

- 1 Vending Commissions
- 2 Adj of Prior period Expenses
- 3
- 4
- 5
- 6
- 7
- 8
- 9
- 10
- 11
- 12
- 13
- 14
- 15
- 16
- 17
- 18
- 19
- 20

TOTALS

Facility Name & ID Number Peterson Park Health Care Center

# 0024463

Report Period Beginning: 01/01/05

Ending:

12/31/05

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

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	2,154	2,320	\$ 104,610	\$ 45.09	1
2	Assistant Director of Nursing					2
3	Registered Nurses	32,319	37,940	1,006,556	26.53	3
4	Licensed Practical Nurses	5,752	6,681	135,149	20.23	4
5	CNAs & Orderlies	111,442	134,974	1,298,453	9.62	5
6	CNA Trainees					6
7	Licensed Therapist	1,898	1,963	69,518	35.41	7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	18,623	22,154	216,669	9.78	10
11	Social Service Workers	12,196	15,310	204,997	13.39	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook	25,218	31,307	332,484	10.62	14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers	8,148	9,313	108,212	11.62	17
18	Housekeepers	12,747	16,310	122,811	7.53	18
19	Laundry	7,373	10,681	90,037	8.43	19
20	Administrator	4,220	4,224	161,995	38.35	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	9,273	10,415	123,419	11.85	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	1,531	1,679	34,649	20.64	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	252,894	305,271	\$ 4,009,559 *	\$ 13.13	34

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

\*\* See instructions.

**B. CONSULTANT SERVICES**

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference		
35	Dietary Consultant	419	\$ 16,886	3-01	35
36	Medical Director	Monthly	6,000	3-09	36
37	Medical Records Consultant	28	1,380	3-10	37
38	Nurse Consultant	39	2,990	3-10	38
39	Pharmacist Consultant	Monthly	6,555	3-10	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant	110	13,135	3-10a	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	42	19,989	3-11	44
45	Social Service Consultant	51	6,109	3-12	45
46	Other(specify) <u>Rehab</u>	111	43,795	3-10	46
47	<u>Doctor 900; Religious Svce 7040</u>	As required	7,940	3-10;3-11	47
48	<u>Purchasing</u>	Monthly	3,384	3-01	48
49	TOTAL (lines 35 - 48)	800	\$ 128,163		49

**C. CONTRACT NURSES**

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

SUPPLEMENTAL SCHEDULE OF STAFFING AND SALARY COSTS

B. CONSULTANT SERVICES

	<u># of Hrs. Actually Worked</u>	<u># of Hrs. Paid and Accrued</u>	<u>Reporting Period Total Salaries, Wages</u>	<u>Average Hourly Wage</u>
PT and OT Salaries	1,722	1,730	\$ 60,563	\$ 35.01

<u>1,722</u>	<u>1,730</u>	\$ <u>60,563</u>	\$ <u>35.01</u>
--------------	--------------	------------------	-----------------



Peterson Park Health Care Center  
01/01/05 to 12/31/05

0024463

Page 21 SUPP

Page 21- Professional Services:

-

Facility Name & ID Number Peterson Park Health Care Center

Report Period Beginning: 01/01/05 Ending:

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

	1 Improvement Type	2 Month & Year Improvement Was Made	3 Total Cost	4 Useful Life	Amount of Expense Amortized Per Year								
					5 FY2002	6 FY2003	7 FY2004	8 FY2005	9 FY2006	10 FY2007	11 FY2008	12 FY2009	13 FY2010
1	Painting & decorating	2005	\$ 1,195	3	\$	\$	\$	\$ 199	\$ 398	\$ 398	\$ 200	\$	\$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$ 1,195		\$	\$	\$	\$ 199	\$ 398	\$ 398	\$ 200	\$	\$

Facility Name &amp; ID Number Peterson Park Health Care Center

**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. Illinois Council Long Term Care--11280
- (3) Did the nursing home make political contributions or payments to a political action organization? Thru Ill Council If YES, have these costs been properly adjusted out of the cost report? Yes
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? \_\_\_\_\_
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes  
What was the average life used for new equipment added during this period? 10
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 28,136 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No  
If YES, give effective date of lease. \_\_\_\_\_
- (9) Are you presently operating under a sublease agreement? \_\_\_\_\_ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES \_\_\_\_\_ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.  
\_\_\_\_\_
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 102,930  
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ \_\_\_\_\_ Has any meal income been offset against related costs? no Indicate the amount. \$ \_\_\_\_\_
- (16) Travel and Transportation
- a. Are there costs included for out-of-state travel? No  
If YES, attach a complete explanation.
- b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ \_\_\_\_\_
- c. What percent of all travel expense relates to transportation of nurses and patients? None
- 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? N/A
- f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? No
- g. Does the facility transport residents to and from day training? No**  
**Indicate the amount of income earned from providing such transportation during this reporting period.** \$ \_\_\_\_\_
- (17) Has an audit been performed by an independent certified public accounting firm? No  
Firm Name: \_\_\_\_\_ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? \_\_\_\_\_ If no, please explain. \_\_\_\_\_
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? Yes  
Attach invoices and a summary of services for all architect and appraisal fees.