

		FOR BHF USE					

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2006
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2006)

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: 0021238

Facility Name: P A Peterson Center for Health

Address: 1311 Parkview Avenue Rockford 61107
 Number City Zip Code

County: Winnebago

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

HFS ID Number: 36-2584799 - 004

Date of Initial License for Current Owners: 1941

Type of Ownership:

<input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT	<input type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL
<input checked="" type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State
<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County
IRS Exemption Code _____	<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: Steve Lavenda **Telephone Number:** (847) 236 - 1111

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 07/01/05 to 06/30/06 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

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

Officer or Administrator of Provider	(Signed) _____	(Date) _____
	(Type or Print Name) _____	
	(Title) _____	
Paid Preparer	(Signed) _____	(Date) _____
	(Print Name and Title) <u>Steven N. Lavenda, C.P.A.</u>	
	(Firm Name & Address) <u>Frost, Ruttenberg & Rothblatt, P.C.</u> <u>111 Pfingsten Road, Suite 300 Deerfield, IL 60015</u>	
	(Telephone) <u>(847) 236-1111</u> Fax # <u>(847) 236-1155</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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number P A Peterson Center for Health

0021238 Report Period Beginning: 07/01/05 Ending: 06/30/06

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 03/23/06

	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>122</u>	Skilled (SNF)	<u>127</u>	<u>45,030</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5	<u>51</u>	Sheltered Care (SC)	<u>32</u>	<u>16,715</u>	5
6		ICF/DD 16 or Less			6
7	<u>173</u>	TOTALS	<u>159</u>	<u>61,745</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>9,046</u>	<u>9,046</u>	8
9	SNF/PED					9
10	ICF	<u>8,824</u>	<u>25,560</u>		<u>34,384</u>	10
11	ICF/DD					11
12	SC		<u>4,959</u>		<u>4,959</u>	12
13	DD 16 OR LESS					13
14	TOTALS	<u>8,824</u>	<u>30,519</u>	<u>9,046</u>	<u>48,389</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 78.37%

D. How many bed-hold days during this year were paid by the Department?

0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.

(E.g., day care, "meals on wheels", outpatient therapy)

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 1941

J. Was the facility purchased or leased after January 1, 1978?

YES Date _____ NO

K. Was the facility certified for Medicare during the reporting year?

YES NO If YES, enter number of beds certified 38 and days of care provided 9,046

Medicare Intermediary AdminaStar Federal

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 06/30/06 Fiscal Year: 06/30/06

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

Facility Name & ID Number P A Peterson Center for Health # 0021238 Report Period Beginning: 07/01/05 Ending: 06/30/06

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
	A. General Services										
1	Dietary	403,030	29,973	23,013	456,016		456,016	456,016			1
2	Food Purchase		297,289		297,289		297,289	(10,453)	286,836		2
3	Housekeeping	126,762	40,124		166,886		166,886	166,886			3
4	Laundry		1,417	149,617	151,034		151,034	151,034			4
5	Heat and Other Utilities			226,808	226,808		226,808	3,014	229,822		5
6	Maintenance	111,232	36,841	136,612	284,685		284,685	554	285,239		6
7	Other (specify):*							1,789	1,789		7
8	TOTAL General Services	641,024	405,644	536,050	1,582,718		1,582,718	(5,096)	1,577,622		8
	B. Health Care and Programs										
9	Medical Director			16,200	16,200		16,200	16,200			9
10	Nursing and Medical Records	3,084,999	40,337	850	3,126,186		3,126,186	3,126,186			10
10a	Therapy										10a
11	Activities	155,903	5,468		161,371		161,371	161,371			11
12	Social Services	102,388		1,343	103,731		103,731	103,731			12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	3,343,290	45,805	18,393	3,407,488		3,407,488		3,407,488		16
	C. General Administration										
17	Administrative	71,774		1,039,494	1,111,268		1,111,268	(657,510)	453,758		17
18	Directors Fees										18
19	Professional Services			102,684	102,684		102,684	86,180	188,864		19
20	Dues, Fees, Subscriptions & Promotions			113,797	113,797		113,797	(88,051)	25,746		20
21	Clerical & General Office Expenses	104,163	38,989	205,826	348,978		348,978	214,199	563,177		21
22	Employee Benefits & Payroll Taxes			1,085,700	1,085,700		1,085,700	1,085,700			22
23	Inservice Training & Education										23
24	Travel and Seminar			5,752	5,752		5,752	20,800	26,552		24
25	Other Admin. Staff Transportation			14,066	14,066		14,066	11,103	25,169		25
26	Insurance-Prop.Liab.Malpractice			290,350	290,350		290,350	31,502	321,852		26
27	Other (specify):*							126,865	126,865		27
28	TOTAL General Administration	175,937	38,989	2,857,669	3,072,595		3,072,595	(254,912)	2,817,683		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,160,251	490,438	3,412,112	8,062,801		8,062,801	(260,008)	7,802,793		29

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

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number P A Peterson Center for Health #0021238 Report Period Beginning: 07/01/05 Ending: 06/30/06

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclassification 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	
	D. Ownership											
30	Depreciation			462,075	462,075	462,075	87,529	549,604				30
31	Amortization of Pre-Op. & Org.											31
32	Interest			190,891	190,891	190,891	14,396	205,287				32
33	Real Estate Taxes			147,529	147,529	147,529		147,529				33
34	Rent-Facility & Grounds						47,365	47,365				34
35	Rent-Equipment & Vehicles			7,608	7,608	7,608	2,624	10,232				35
36	Other (specify):*			34,495	34,495	34,495		34,495				36
37	TOTAL Ownership			842,598	842,598	842,598	151,914	994,512				37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		558,870	1,626,068	2,184,938	2,184,938		2,184,938				39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			66,840	66,840	66,840	2,085	68,925				42
43	Other (specify):*	31,177			31,177	31,177		31,177				43
44	TOTAL Special Cost Centers	31,177	558,870	1,692,908	2,282,955	2,282,955	2,085	2,285,040				44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	4,191,428	1,049,308	5,947,618	11,188,354	11,188,354	(106,009)	11,082,345				45

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number P A Peterson Center for Health

0021238

Report Period Beginning: 07/01/05

Ending: 06/30/06

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	(10,453)	02		4
5	Telephone, TV & Radio in Resident Rooms	(23,030)	21		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	42,267	30		9
10	Interest and Other Investment Income	(277)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax		02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(100,530)	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	(15,102)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (107,125)		\$	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)	1,116		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 1,116		36
37	TOTAL ADJUSTMENTS (A) and (B)	\$ (106,009)		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	TOTAL (C): (sum of lines 38-46)			\$		47

BHF USE ONLY					
48		49		50	51
					52

SEE ACCOUNTANTS' COMPILATION REPORT

NON-ALLOWABLE EXPENSES	Amount	Sch. V Line	Reference
1 Capitalized R&M	\$ (7,187)	06	1
2 Med Tax	2,003	42	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
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92			92
93			93
94			94
95			95
96			96
97			97
98			98
99			99
100			100
101 Total	(15,102)		101

STATE OF ILLINOIS

Summary A

Facility Name & ID Number P A Peterson Center for Health

0021238

Report Period Beginning:

07/01/05

Ending:

06/30/06

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary													1
2	Food Purchase	(10,453)											(10,453)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities			2,991	23								3,014	5
6	Maintenance	(17,187)		17,613	128								554	6
7	Other (specify):*			1,783	6								1,789	7
8	TOTAL General Services	(27,640)		22,387	157								(5,096)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records													10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*													15
16	TOTAL Health Care and Programs													16
	C. General Administration													
17	Administrative			(331,575)	(188,602)	(137,333)							(657,510)	17
18	Directors Fees													18
19	Professional Services			47,892	27,832	10,456							86,180	19
20	Fees, Subscriptions & Promotions	(100,530)		2,749	9,514	216							(88,051)	20
21	Clerical & General Office Expenses	(23,030)		30,287	118,312	88,630							214,199	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar			19,749	797	254							20,800	24
25	Other Admin. Staff Transportation			6,762	2,151	2,190							11,103	25
26	Insurance-Prop.Liab.Malpractice			30,489	531	482							31,502	26
27	Other (specify):*			70,504	21,643	34,718							126,865	27
28	TOTAL General Administration	(123,560)		(123,143)	(7,822)	(387)							(254,912)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(151,200)		(100,756)	(7,665)	(387)							(260,008)	29

STATE OF ILLINOIS

Facility Name & ID Number P A Peterson Center for Health

0021238

Report Period Beginning:

07/01/05 Ending:

Summary B

06/30/06

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	42,267		40,093	5,029	140							87,529	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(277)		14,673									14,396	32
33	Real Estate Taxes													33
34	Rent-Facility & Grounds			46,084	1,281								47,365	34
35	Rent-Equipment & Vehicles			1,289	1,089	246							2,624	35
36	Other (specify):*													36
37	TOTAL Ownership	41,990		102,139	7,399	386							151,914	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers													39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee	2,085											2,085	42
43	Other (specify):*													43
44	TOTAL Special Cost Centers	2,085											2,085	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(107,125)		1,383	(266)	(1)							(106,009)	45

Facility Name & ID Number P A Peterson Center for Health

0021238

Report Period Beginning:

07/01/05

Ending:

06/30/06

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
N/A		St. Matthews	Park Ridge	Vesper Mgmt Corp	Des Plaines	Mgmt Co.
				LSSI	Des Plaines	Corp. Office

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. YES 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		\$			\$	\$
2	V						
3	V						
4	V						
5	V						
6	V						
7	V						
8	V						
9	V						
10	V						
11	V						
12	V						
13	V						
14	Total		\$			\$	\$ *

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number P A Peterson Center for Health # 0021238 Report Period Beginning: 07/01/05 Ending: 06/30/06

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	Salaries & Wages	Lutheran Social Services of Illinois	100.00%	381,986	381,986	15
16	V	27	Empl Benefits & Taxes	Lutheran Social Services of Illinois	100.00%	70,553	70,553	16
17	V	19	Prof Fees & Contracts	Lutheran Social Services of Illinois	100.00%	47,892	47,892	17
18	V	21	Supplies, Telephone,	Lutheran Social Services of Illinois	100.00%	29,375	29,375	18
19	V	34	Rental of Space	Lutheran Social Services of Illinois	100.00%	46,084	46,084	19
20	V	5	Utilities	Lutheran Social Services of Illinois	100.00%	2,991	2,991	20
21	V	6	Bldg Repairs & Maintenance	Lutheran Social Services of Illinois	100.00%	384	384	21
22	V	32	Interest	Lutheran Social Services of Illinois	100.00%	14,673	14,673	22
23	V	33	Real Estate Taxes	Lutheran Social Services of Illinois	100.00%			23
24	V	26	Insurance	Lutheran Social Services of Illinois	100.00%	30,489	30,489	24
25	V	27	Advertising & Promotions	Lutheran Social Services of Illinois	100.00%	(49)	(49)	25
26	V	25	Transportation	Lutheran Social Services of Illinois	100.00%	6,762	6,762	26
27	V	35	Car Rental	Lutheran Social Services of Illinois	100.00%	102	102	27
28	V	24	Conferences & Conventions	Lutheran Social Services of Illinois	100.00%	19,749	19,749	28
29	V	20	Subscriptions, Dues, Awards	Lutheran Social Services of Illinois	100.00%	2,749	2,749	29
30	V	6	Furniture & Fixtures	Lutheran Social Services of Illinois	100.00%	430	430	30
31	V	6	Machinery & Equipment	Lutheran Social Services of Illinois	100.00%			31
32	V	35	Equipment Rental	Lutheran Social Services of Illinois	100.00%	1,187	1,187	32
33	V	6	Equipment Repair & Maint.	Lutheran Social Services of Illinois	100.00%	16,799	16,799	33
34	V	20	Employee Recruitment	Lutheran Social Services of Illinois	100.00%			34
35	V	7	Security & Waste Removal	Lutheran Social Services of Illinois	100.00%	1,783	1,783	35
36	V	21	All Other Miscellaneous	Lutheran Social Services of Illinois	100.00%	912	912	36
37	V	30	Depreciation	Lutheran Social Services of Illinois	100.00%	40,093	40,093	37
38	V	17	Management Fees	Lutheran Social Services of Illinois	100.00%		(713,561)	38
39	Total		\$ 713,561			\$ 714,944	\$ * 1,383	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number P A Peterson Center for Health# 0021238Report Period Beginning: 07/01/05Ending: 06/30/06

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	21	Salaries & Wages	Lutheran Social Services of Illinois	100.00%	111,191	111,191	15
16	V	27	Empl Benefits & Taxes	Lutheran Social Services of Illinois	100.00%	21,643	21,643	16
17	V	19	Prof Fees & Contracts	Lutheran Social Services of Illinois	100.00%	27,832	27,832	17
18	V	21	Supplies, Telephone,	Lutheran Social Services of Illinois	100.00%	6,927	6,927	18
19	V	34	Rental of Space	Lutheran Social Services of Illinois	100.00%	1,281	1,281	19
20	V	5	Utilities	Lutheran Social Services of Illinois	100.00%	23	23	20
21	V	6	Bldg Repairs & Maintenance	Lutheran Social Services of Illinois	100.00%			21
22	V	32	Interest	Lutheran Social Services of Illinois	100.00%			22
23	V	33	Real Estate Taxes	Lutheran Social Services of Illinois	100.00%			23
24	V	26	Insurance	Lutheran Social Services of Illinois	100.00%	531	531	24
25	V	27	Advertising & Promotions	Lutheran Social Services of Illinois	100.00%			25
26	V	25	Transportation	Lutheran Social Services of Illinois	100.00%	2,151	2,151	26
27	V	35	Car Rental	Lutheran Social Services of Illinois	100.00%	219	219	27
28	V	24	Conferences & Conventions	Lutheran Social Services of Illinois	100.00%	797	797	28
29	V	20	Subscriptions, Dues, Awards	Lutheran Social Services of Illinois	100.00%	850	850	29
30	V	6	Furniture & Fixtures	Lutheran Social Services of Illinois	100.00%	66	66	30
31	V	6	Machinery & Equipment	Lutheran Social Services of Illinois	100.00%			31
32	V	35	Equipment Rental	Lutheran Social Services of Illinois	100.00%	870	870	32
33	V	6	Equipment Repair & Maint.	Lutheran Social Services of Illinois	100.00%	62	62	33
34	V	20	Employee Recruitment	Lutheran Social Services of Illinois	100.00%	8,664	8,664	34
35	V	7	Security & Waste Removal	Lutheran Social Services of Illinois	100.00%	6	6	35
36	V	21	All Other Miscellaneous	Lutheran Social Services of Illinois	100.00%	194	194	36
37	V	30	Depreciation	Lutheran Social Services of Illinois	100.00%	5,029	5,029	37
38	V	17	Management Fees	Lutheran Social Services of Illinois	100.00%		(188,602)	38
39	Total		\$ 188,602			\$ 188,336	\$ *	(266) 39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number P A Peterson Center for Health# 0021238Report Period Beginning: 07/01/05Ending: 06/30/06

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	21 Salaries & Wages		Lutheran Social Services of Illinois	100.00%	81,931	81,931	15
16	V	27 Empl Benefits & Taxes		Lutheran Social Services of Illinois	100.00%	33,990	33,990	16
17	V	19 Prof Fees & Contracts		Lutheran Social Services of Illinois	100.00%	10,456	10,456	17
18	V	21 Supplies, Telephone,		Lutheran Social Services of Illinois	100.00%	6,695	6,695	18
19	V	34 Rental of Space		Lutheran Social Services of Illinois	100.00%			19
20	V	5 Utilities		Lutheran Social Services of Illinois	100.00%			20
21	V	6 Bldg Repairs & Maintenance		Lutheran Social Services of Illinois	100.00%			21
22	V	32 Interest		Lutheran Social Services of Illinois	100.00%			22
23	V	33 Real Estate Taxes		Lutheran Social Services of Illinois	100.00%			23
24	V	26 Insurance		Lutheran Social Services of Illinois	100.00%	482	482	24
25	V	27 Advertising & Promotions		Lutheran Social Services of Illinois	100.00%	728	728	25
26	V	25 Transportation		Lutheran Social Services of Illinois	100.00%	2,190	2,190	26
27	V	35 Car Rental		Lutheran Social Services of Illinois	100.00%	34	34	27
28	V	24 Conferences & Conventions		Lutheran Social Services of Illinois	100.00%	254	254	28
29	V	20 Subscriptions, Dues, Awards		Lutheran Social Services of Illinois	100.00%	216	216	29
30	V	6 Furniture & Fixtures		Lutheran Social Services of Illinois	100.00%			30
31	V	6 Machinery & Equipment		Lutheran Social Services of Illinois	100.00%			31
32	V	35 Equipment Rental		Lutheran Social Services of Illinois	100.00%	212	212	32
33	V	6 Equipment Repair & Maint.		Lutheran Social Services of Illinois	100.00%			33
34	V	20 Employee Recruitment		Lutheran Social Services of Illinois	100.00%			34
35	V	7 Security & Waste Removal		Lutheran Social Services of Illinois	100.00%			35
36	V	21 All Other Miscellaneous		Lutheran Social Services of Illinois	100.00%	4	4	36
37	V	30 Depreciation		Lutheran Social Services of Illinois	100.00%	140	140	37
38	V	17 Management Fees	137,333	Lutheran Social Services of Illinois	100.00%		(137,333)	38
39	Total		\$ 137,333			\$ 137,332	\$ * (1)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

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			\$			\$		15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

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			\$			\$		15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

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

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			\$			\$		15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

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			\$			\$		15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

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

Facility Name & ID Number P A Peterson Center for Health

0021238

Report Period Beginning: 07/01/05

Ending: 06/30/06

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			\$			\$		15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number P A Peterson Center for Health

0021238

Report Period Beginning: 07/01/05

Ending: 06/30/06

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			\$			\$		15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number P A Peterson Center for Health # 0021238 Report Period Beginning: 07/01/05 Ending: 06/30/06

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	N/A								\$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13								TOTAL	\$	13

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number P A Peterson Center for Health

0021238

Report Period Beginning: 07/01/05

Ending: 06/30/06

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

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

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

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					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number P A Peterson Center for Health# 0021238

Report Period Beginning:

07/01/05Ending: 06/30/06

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

Name of Related Organization

Lutheran Social Services of Illinois

Street Address

1001 E. Touhy Avenue, Suite 50

City / State / Zip Code

Des Plaines, Illinois 60018

Phone Number

(847) 635-4600

Fax Number

(847) 635-6764

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

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	Salaries & Wages	Non-Capital Direct Costs	32,568,454	224	2,973,157	2,973,157	4,184,336	381,986	1
2	27	Empl Benefits & Taxes		32,568,454	224	549,142	4,184,336	4,184,336	70,553	2
3	19	Prof Fees & Contracts		32,568,454	224	372,765	4,184,336	4,184,336	47,892	3
4	21	Supplies, Telephone,		32,568,454	224	228,636	4,184,336	4,184,336	29,375	4
5		Postage, Out. Printing		32,568,454	224		4,184,336	4,184,336		5
6	34	Rental of Space		32,568,454	224	358,692	4,184,336	4,184,336	46,084	6
7	5	Utilities		32,568,454	224	23,282	4,184,336	4,184,336	2,991	7
8	6	Bldg Repairs & Maintenance		32,568,454	224	2,989	4,184,336	4,184,336	384	8
9	32	Interest		32,568,454	224	114,210	4,184,336	4,184,336	14,673	9
10	33	Real Estate Taxes		32,568,454	224		4,184,336	4,184,336		10
11	26	Insurance		32,568,454	224	237,309	4,184,336	4,184,336	30,489	11
12	27	Advertising & Promotions		32,568,454	224	(379)	4,184,336	4,184,336	(49)	12
13	25	Transportation		32,568,454	224	52,634	4,184,336	4,184,336	6,762	13
14	35	Car Rental		32,568,454	224	793	4,184,336	4,184,336	102	14
15	24	Conferences & Conventions		32,568,454	224	153,711	4,184,336	4,184,336	19,749	15
16	20	Subscriptions, Dues, Awards		32,568,454	224	21,393	4,184,336	4,184,336	2,749	16
17	6	Furniture & Fixtures		32,568,454	224	3,344	4,184,336	4,184,336	430	17
18	6	Machinery & Equipment		32,568,454	224		4,184,336	4,184,336		18
19	35	Equipment Rental		32,568,454	224	9,241	4,184,336	4,184,336	1,187	19
20	6	Equipment Repair & Maint.		32,568,454	224	130,757	4,184,336	4,184,336	16,799	20
21	20	Employee Recruitment		32,568,454	224		4,184,336	4,184,336		21
22	7	Security & Waste Removal		32,568,454	224	13,877	4,184,336	4,184,336	1,783	22
23	21	All Other Miscellaneous		32,568,454	224	7,098	4,184,336	4,184,336	912	23
24	30	Depreciation		32,568,454	224	312,062	4,184,336	4,184,336	40,093	24
25	TOTALS					\$ 5,564,713	\$ 2,973,157		\$ 714,944	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number P A Peterson Center for Health

0021238

Report Period Beginning: 07/01/05

Ending: 06/30/06

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

1	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	21	Salaries & Wages	52,461,326	218	1,105,382	1,105,382	5,277,134	111,191	1
2	27	Empl Benefits & Taxes	52,461,326	218	215,157		5,277,134	21,643	2
3	19	Prof Fees & Contracts	52,461,326	218	276,688		5,277,134	27,832	3
4	21	Supplies, Telephone,	52,461,326	218			5,277,134		4
5		Postage, Out. Printing	52,461,326	218	68,860		5,277,134	6,927	5
6	34	Rental of Space	52,461,326	218	12,735		5,277,134	1,281	6
7	5	Utilities	52,461,326	218	233		5,277,134	23	7
8	6	Bldg Repairs & Maintenance	52,461,326	218			5,277,134		8
9	32	Interest	52,461,326	218			5,277,134		9
10	33	Real Estate Taxes	52,461,326	218			5,277,134		10
11	26	Insurance	52,461,326	218	5,274		5,277,134	531	11
12	27	Advertising & Promotions	52,461,326	218			5,277,134		12
13	25	Transportation	52,461,326	218	21,388		5,277,134	2,151	13
14	35	Car Rental	52,461,326	218	2,173		5,277,134	219	14
15	24	Conferences & Conventions	52,461,326	218	7,926		5,277,134	797	15
16	20	Subscriptions, Dues, Awards	52,461,326	218	8,446		5,277,134	850	16
17	6	Furniture & Fixtures	52,461,326	218	661		5,277,134	66	17
18	6	Machinery & Equipment	52,461,326	218			5,277,134		18
19	35	Equipment Rental	52,461,326	218	8,648		5,277,134	870	19
20	6	Equipment Repair & Maint.	52,461,326	218	620		5,277,134	62	20
21	20	Employee Recruitment	52,461,326	218	86,128		5,277,134	8,664	21
22	7	Security & Waste Removal	52,461,326	218	60		5,277,134	6	22
23	21	All Other Miscellaneous	52,461,326	218	1,927		5,277,134	194	23
24	30	Depreciation	52,461,326	218	49,999		5,277,134	5,029	24
25	TOTALS				\$ 1,872,305	\$ 1,105,382		\$ 188,336	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number P A Peterson Center for Health# 0021238

Report Period Beginning:

07/01/05Ending: 06/30/06

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

Name of Related Organization

Lutheran Social Services of Illinois

Street Address

1001 E. Touhy Avenue, Suite 50

City / State / Zip Code

Des Plaines, Illinois 60018

Phone Number

(847) 635-4600

Fax Number

(847) 635-6764

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

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	21	Salaries & Wages	7,460,771	2	146,085	146,085	4,184,336	81,931	1
2	27	Empl Benefits & Taxes	7,460,771	2	60,605		4,184,336	33,990	2
3	19	Prof Fees & Contracts	7,460,771	2	18,643		4,184,336	10,456	3
4	21	Supplies, Telephone,	7,460,771	2	11,937		4,184,336	6,695	4
5		Postage, Out. Printing	7,460,771	2			4,184,336		5
6	34	Rental of Space	7,460,771	2			4,184,336		6
7	5	Utilities	7,460,771	2			4,184,336		7
8	6	Bldg Repairs & Maintenance	7,460,771	2			4,184,336		8
9	32	Interest	7,460,771	2			4,184,336		9
10	33	Real Estate Taxes	7,460,771	2			4,184,336		10
11	26	Insurance	7,460,771	2	859		4,184,336	482	11
12	27	Advertising & Promotions	7,460,771	2	1,298		4,184,336	728	12
13	25	Transportation	7,460,771	2	3,905		4,184,336	2,190	13
14	35	Car Rental	7,460,771	2	61		4,184,336	34	14
15	24	Conferences & Conventions	7,460,771	2	453		4,184,336	254	15
16	20	Subscriptions, Dues, Awards	7,460,771	2	386		4,184,336	216	16
17	6	Furniture & Fixtures	7,460,771	2			4,184,336		17
18	6	Machinery & Equipment	7,460,771	2			4,184,336		18
19	35	Equipment Rental	7,460,771	2	378		4,184,336	212	19
20	6	Equipment Repair & Maint.	7,460,771	2			4,184,336		20
21	20	Employee Recruitment	7,460,771	2			4,184,336		21
22	7	Security & Waste Removal	7,460,771	2			4,184,336		22
23	21	All Other Miscellaneous	7,460,771	2	8		4,184,336	4	23
24	30	Depreciation	7,460,771	2	250		4,184,336	140	24
25	TOTALS				\$ 244,868	\$ 146,085		\$ 137,332	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number P A Peterson Center for Health

0021238

Report Period Beginning: 07/01/05

Ending: 06/30/06

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number P A Peterson Center for Health

0021238

Report Period Beginning: 07/01/05

Ending: 06/30/06

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	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					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number P A Peterson Center for Health

0021238

Report Period Beginning: 07/01/05

Ending: 06/30/06

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	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					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number P A Peterson Center for Health

0021238

Report Period Beginning: 07/01/05

Ending: 06/30/06

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	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					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number P A Peterson Center for Health

0021238

Report Period Beginning: 07/01/05

Ending: 06/30/06

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number P A Peterson Center for Health

0021238

Report Period Beginning: 07/01/05

Ending: 06/30/06

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	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					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

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	Name of Lender	2		3	4	5	6		8	9	10						
		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			
A. Directly Facility Related																	
Long-Term																	
1	Tax Exempt Bonds		X	Refinance Mortgage	N/A	9/23/1993	\$ 4,388,000	\$ 4,388,000	8/15/2020		\$ 190,892	1					
2												2					
3												3					
4												4					
5	See Supplemental Schedule											5					
Working Capital																	
6	Allocate LSSI		X								14,673	6					
7												7					
8	See Supplemental Schedule											8					
9	TOTAL Facility Related						\$ 4,388,000	\$ 4,388,000			\$ 205,565	9					
B. Non-Facility Related*																	
10	Interest Income		X								(277)	10					
11												11					
12												12					
13	See Supplemental Schedule											13					
14	TOTAL Non-Facility Related						\$	\$			(277)	14					
15	TOTALS (line 9+line14)						\$ 4,388,000	\$ 4,388,000			\$ 205,288	15					

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ None Line # N/A

* 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

P A Peterson Center for Health

0021238

Report Period Beginning:

07/01/05

Ending:

06/30/06

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE - SUPPLEMENTAL SCHEDULE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6		7	8	9	10						
		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			
	A. Directly Facility Related																	
	Long-Term																	
1							\$	\$			\$	1						
2												2						
3												3						
4												4						
5												5						
6												6						
7	TOTAL Long-Term																	
	Working Capital																	
8							\$	\$			\$	8						
9												9						
10												10						
11												11						
12												12						
13												13						
14	TOTAL Working Capital																	
	B. Non-Facility Related*																	
15							\$	\$			\$	15						
16												16						
17												17						
18												18						
19												19						
20	TOTAL Non-Facility Related																	

* 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.)

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2005 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 2005 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2005.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2005 real estate tax bill to Healthcare and Family Services, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2006 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.

2005 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME P A Peterson Center for Health COUNTY Winnebago

FACILITY IDPH LICENSE NUMBER 0021238

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE (847) 236-1111 FAX #: (847) 236-1155

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2005 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 2005.

(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>163B600 12-19-101-001</u>	<u>Long Term Care Property</u>	\$ <u>145,939.32</u>	\$ <u>145,939.32</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>145,939.32</u>	\$ <u>145,939.32</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 2005 tax bills which were listed in Section A to this statement. Be sure to use the 2005 tax bill which is normally paid during 2006.

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:** 2000 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 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 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 Office of Health Finance at (217) 782-1630.

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME P A Peterson Center for Health COUNTY Winnebago

FACILITY IDPH LICENSE NUMBER 0021238

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE (847) 236-1111 FAX #: (847) 236-1155

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

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

B. Real Estate Tax Cost Allocations

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

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

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

Facility Name & ID Number P A Peterson Center for Health

0021238 Report Period Beginning:

07/01/05 Ending:

06/30/06

X. BUILDING AND GENERAL INFORMATION:

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

C. Does the Operating Entity? (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).

None

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>192,020</u>	<u>1985</u>	<u>\$ 8,455</u>	1
2					2
3	TOTALS	192,020		\$ 8,455	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number P A Peterson Center for Health

0021238

Report Period Beginning:

07/01/05

Ending:

06/30/06

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-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	159		1942	1942	\$ 95,858	\$	50	\$	\$	\$ 95,858	4
5			1979	1979	5,596,922	139,989	40	139,923	(66)	3,777,339	5
6											6
7											7
8											8
Improvement Type**											
9	Various		1969		5,300		20			5,300	9
10	Various		1975		9,226		20			9,226	10
11	Various		1977		10,074		20			10,074	11
12	Various		1980		71,947		20	144	144	71,049	12
13	Various		1981		7,309		20			7,309	13
14	Various		1982		6,151		20			6,151	14
15	Various		1983		30,936		20			30,936	15
16	Various		1984		15,554		20			15,554	16
17	Various		1985		4,850		20			4,850	17
18	Various		1986		21,640		20			21,640	18
19	Various		1988		18,312		20			18,312	19
20	Various		1989		71,006		20			71,006	20
21	Various		1990		104,815		20	5,031	5,031	69,141	21
22	Various		1991		64,328		20			64,328	22
23	Various		1992		20,528		20			20,528	23
24	Various		1993		18,315		20			18,315	24
25	Various		1994		86,971		20			86,971	25
26	Various		1995		780,081		20	38,336	38,336	434,248	26
27	Various		1997		2,685		20	134	134	2,294	27
28	Various		1998		149,521		20	7,476	7,476	88,625	28
29	Various		1999		22,062		20	1,103	1,103	17,114	29
30	Various		2000		63,500		20	3,175	3,175	16,066	30
31	Various		2001		170,563		20	8,528	8,528	57,430	31
32	Various		2002		79,186		20	3,959	3,959	31,435	32
33											33
34											34
35											35
36											36

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

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

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number P A Peterson Center for Health

0021238

Report Period Beginning:

07/01/05

Ending:

06/30/06

XI. OWNERSHIP COSTS (continued)

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

1	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		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67								67
68		60,008	45,262		6,001	(39,261)	48,008	68
69			157,505			(157,505)		69
70		\$ 7,587,648	\$ 342,756		\$ 213,811	\$ (128,946)	\$ 5,099,108	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number P A Peterson Center for Health

0021238

Report Period Beginning:

07/01/05

Ending:

06/30/06

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 12A, Carried Forward		\$ 7,587,648	\$ 342,756		\$ 213,811	\$ (128,946)	\$ 5,099,108	1
2	<u>Drapery, Cubicles, Spools, Cabinets, Shower, Windows, Lamps, Pa</u>	2003	82,495		20	4,125	4,125	21,672	2
3	<u>Duct Work For Air Conditioning</u>	2003	1,059		20	53	53	503	3
4	<u>Drapery & Cubicles- Ground Floor</u>	2003	5,535		20	277	277	1,407	4
5	<u>Spools And Border- Ground Floor</u>	2003	2,692		20	135	135	685	5
6	<u>Cabinets In Activity Room- Ground Floor</u>	2003	2,700		20	135	135	686	6
7	<u>Shower Tile, Bar, & Curtains- Ground Floor</u>	2003	5,655		20	283	283	1,438	7
8	<u>Window Valances & Blinds- Ground Floor</u>	2003	1,584		20	79	79	402	8
9	<u>Furniture & Lamps- Ground Floor</u>	2003	11,887		20	594	594	3,022	9
10	<u>Painting And Border- Activity Room</u>	2003	1,098		20	55	55	279	10
11	<u>Framed & Matted Art- Ground Floor</u>	2003	880		20	44	44	224	11
12	<u>Dumpster- Ground Floor</u>	2003	468		20	23	23	118	12
13	<u>Cheshire Chair Lifts- Ground Floor</u>	2003	4,278		20	214	214	1,961	13
14	<u>Corridors, Walls, Doors, Rails- Ground Floor</u>	2003	17,076		20	854	854	7,826	14
15	<u>Carpeting And Cove- Ground Floor</u>	2003	29,523		20	1,476	1,476	7,505	15
16	<u>Emergency Plumbing- Hot Water</u>	2004	5,048		20	252	252	777	16
17	<u>Emergency Plumbing- Hot Water</u>	2004	465		20	23	23	71	17
18	<u>Emergency Outlet Circuits</u>	2004	4,575		20	229	229	419	18
19	<u>Piston Repair For Elevator- Cylinder</u>	2005	8,061		20	403	403	685	19
20	<u>Emergency Plumbing- Architect</u>	2005	285		20	14	14	15	20
21	<u>Corner Guards, Wall Sconces, Carpet, Kick Plate</u>	2005	4,507		20	225	225	244	21
22	<u>Piston Replacement For Elevator</u>	2005	1,064		20	53	53	72	22
23	<u>Piston Replacement For Elevator</u>	2005	24,182		20	1,209	1,209	1,649	23
24	<u>Ground Floor- Payment On Chairs, Cubicles, Etc</u>	2005	10,959		20	548	548	676	24
25	<u>Hvac Architect Fees Copies& Drafting</u>	2005	2,423		20	121	121	149	25
26	<u>Fire Damper Remodeling Project</u>	2005	115,128		20	5,756	5,756	5,945	26
27	<u>Instalation Of Fire Dampers</u>	2005	63,740		20	3,187	3,187	3,292	27
28	<u>Window & Air- Fitness Center & Computer Room</u>	2005	73,833		20	3,692	3,692	3,813	28
29	<u>Hvac Rehab- First Floor</u>	2005	76,077		20	3,804	3,804	4,187	29
30	<u>Hvac Rehab- First Floor</u>	2005	82,560		20	4,128	4,128	4,264	30
31	<u>Drafter & Contracts On Hvac</u>	2005	1,550		20	78	78	78	31
32	<u>Copies & Plots On Hvac</u>	2005	4,869		20	243	243	243	32
33	<u>Boiler- Hot Water Valve, Motor, & Ignitor</u>	2005	12,512		20	626	626	626	33
34	TOTAL (lines 1 thru 33)		\$ 8,246,416	\$ 342,756		\$ 246,749	\$ (96,007)	\$ 5,174,041	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number P A Peterson Center for Health

0021238

Report Period Beginning:

07/01/05

Ending:

06/30/06

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 12B, Carried Forward		\$ 8,246,416	\$ 342,756		\$ 246,749	\$ (96,007)	\$ 5,174,041	1
2	Hvac, Drafter	2005	2,812		20	141	141	141	2
3	Hvac Rehab- First Floor	2005	27,866		20	1,393	1,393	1,393	3
4	Norstar- Shear& Install 2 Pieces 48X48 Galvanized	2005	3,465		20	173	173	173	4
5	Installation Of Fire Dampers	2005	20,473		20	1,024	1,024	1,024	5
6	Installation Of Fire Dampers	2005	140,671		20	7,034	7,034	7,034	6
7	Landscaping And Design	2005	2,031		20	102	102	102	7
8	Lcn Door Holders/ Closers For Residents' Rooms	2005	5,520		20	276	276	276	8
9	Ventillation Upgrades- Hvac	2005	33,745		20	1,687	1,687	1,687	9
10	Ventillation Upgrade- Hvac	2005	160,919		20	8,046	8,046	8,046	10
11	Installation Of Fire Dampers	2005	84,247		20	4,212	4,212	4,212	11
12	Ventillation Upgrades- Hvac	2005	101,065		20	5,053	5,053	5,053	12
13	Drywall, Taping, Fire Cauking, Sidewalk, Wiring	2005	59,936		20	2,997	2,997	2,997	13
14	Parking Lot Landscaping And Rehabilitation	2005	1,231		20	62	62	62	14
15	Sidewalk Sections	2005	6,461		20	323	323	323	15
16	Skilled Medicare Room- Drafter	2005	8,819		20	441	441	441	16
17	Review Water Supply	2005	191		20	10	10	10	17
18	Skilled Medicare Room-Reports & Contracts	2005	315		20	16	16	16	18
19	Sprinkler System& City Code	2005	1,675		20	84	84	84	19
20	First Floor Electrical & Hvac	2005	2,058		20	103	103	103	20
21	Hvac Architect Fees- Plan Review	2005	2,400		20	120	120	120	21
22	Carpet & Paint Samples	2005	2,470		20	123	123	123	22
23	Duane Morris, Bed Conversion	2005	3,383		20	169	169	169	23
24	Hvac Survey	2005	5,461		20	273	273	273	24
25	Hvac Rehab- First Floor	2005	6,803		20	340	340	340	25
26	Pa Peterson -Hvac Project Rvw -Fee	2005	8,695		20	435	435	435	26
27	Fire Damper	2005	13,472		20	674	674	674	27
28	1St Floor Electrical & Hvac	2005	18,287		20	914	914	914	28
29	Hvac Electrical, & Ventillation	2005	25,455		20	1,273	1,273	1,273	29
30	Remodel Fire Dampers	2005	56,719		20	2,836	2,836	2,836	30
31	Hvac Rehab- First Floor	2005	74,393		20	3,720	3,720	3,720	31
32	Fire Damper Project Pa Peterson	2005	80,909		20	4,045	4,045	4,045	32
33	Ventilation Upgrades- Hvac	2005	103,120		20	5,156	5,156	5,156	33
34	TOTAL (lines 1 thru 33)		\$ 9,311,485	\$ 342,756		\$ 300,002	\$ (42,754)	\$ 5,227,295	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number P A Peterson Center for Health

0021238

Report Period Beginning:

07/01/05

Ending:

06/30/06

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 12C, Carried Forward		\$ 9,311,485	\$ 342,756		\$ 300,002	\$ (42,754)	\$ 5,227,295	1
2	Hvac & Electrical Systems	2005	122,767		20	6,138	6,138	6,138	2
3	Ventilation Upgrades- Hvac	2005	148,374		20	7,419	7,419	7,419	3
4	Ventilation Upgrades	2005	244,601		20	12,230	12,230	12,230	4
5	Hvac Upgrade & Fire Damper	2006	61,560		20	3,078	3,078	3,078	5
6	Hvac, Drafter	2006	698		20	35	35	35	6
7	Installation Of Fire Dampers	2006	14,750		20	738	738	738	7
8	Fire Dampers	2006	14,823		20	741	741	741	8
9	Ventilation Upgrades- Hvac	2006	25,716		20	1,286	1,286	1,286	9
10	Ventilation Upgrades- Hvac	2006	33,058		20	1,653	1,653	1,653	10
11	Extension Of Pole Base In Parking Lot	2006	590		20	30	30	30	11
12	Concrete For Pole Base	2006	84		20	4	4	4	12
13	Relocate Base And Replaced Pole	2006	3,460		20	173	173	173	13
14	Safety Cable Rails In Stairwells	2006	14,700		20	735	735	735	14
15	Flooring In 2Nd Floor Dining Room	2006	12,075		20	604	604	604	15
16	Parking Lot Expansion- Additional Parking Spaces	2006	22,475		20	1,124	1,124	1,124	16
17	Penthouse Chase Lighting	2006	650		20	33	33	33	17
18	Commercial Mechanical- Sink Addition	2006	6,160		20	308	308	308	18
19	Parking Lot Pole Replacement	2006	13,300		20	665	665	665	19
20	Install Lights To Center Court	2006	24,260		20	1,213	1,213	1,213	20
21	3 Door Alarms For Stairways	2006	3,250		20	163	163	163	21
22	Two Whirlpools	2006	21,339		20	1,067	1,067	1,067	22
23	Two Whirlpool Bathtubs	2006	1,956		20	98	98	98	23
24	Walk-In Cooler Repair	2006	2,887		20	144	144	144	24
25	Repair Fire Protection Main	2006	12,100		20	605	605	605	25
26	Landscaping	2006	2,200		20	110	110	110	26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 10,119,318	\$ 342,756		\$ 340,394	\$ (2,362)	\$ 5,267,686	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1	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		\$ 10,119,318	\$ 342,756		\$ 340,394	\$ (2,362)	\$ 5,267,686	1
2								2
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31								31
32								32
33								33
34	TOTAL (lines 1 thru 33)	\$ 10,119,318	\$ 342,756		\$ 340,394	\$ (2,362)	\$ 5,267,686	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

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 12E, Carried Forward	\$ 10,119,318	\$ 342,756		\$ 340,394	\$ (2,362)	\$ 5,267,686		1
2									2
3									3
4									4
5									5
6									6
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29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)	\$ 10,119,318	\$ 342,756		\$ 340,394	\$ (2,362)	\$ 5,267,686		34

SEE ACCOUNTANTS' COMPILATION REPORT

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

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 12F, Carried Forward	\$ 10,119,318	\$ 342,756		\$ 340,394	\$ (2,362)	\$ 5,267,686		1
2									2
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4									4
5									5
6									6
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30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)	\$ 10,119,318	\$ 342,756		\$ 340,394	\$ (2,362)	\$ 5,267,686		34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1	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		\$ 10,119,318	\$ 342,756		\$ 340,394	\$ (2,362)	\$ 5,267,686	1
2								2
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32								32
33								33
34	TOTAL (lines 1 thru 33)	\$ 10,119,318	\$ 342,756		\$ 340,394	\$ (2,362)	\$ 5,267,686	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

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 12H, Carried Forward		\$ 10,119,318	\$ 342,756		\$ 340,394	\$ (2,362)	\$ 5,267,686	1
2									2
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4									4
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31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 10,119,318	\$ 342,756		\$ 340,394	\$ (2,362)	\$ 5,267,686	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

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 12I, Carried Forward	\$ 10,119,318	\$ 342,756		\$ 340,394	\$ (2,362)	\$ 5,267,686		1
2									2
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32									32
33									33
34	TOTAL (lines 1 thru 33)	\$ 10,119,318	\$ 342,756		\$ 340,394	\$ (2,362)	\$ 5,267,686		34

SEE ACCOUNTANTS' COMPILATION REPORT

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

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 12J, Carried Forward	\$ 10,119,318	\$ 342,756		\$ 340,394	\$ (2,362)	\$ 5,267,686		1
2									2
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4									4
5									5
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31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)	\$ 10,119,318	\$ 342,756		\$ 340,394	\$ (2,362)	\$ 5,267,686		34

SEE ACCOUNTANTS' COMPILATION REPORT

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

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 12K, Carried Forward		\$ 10,119,318	\$ 342,756		\$ 340,394	\$ (2,362)	\$ 5,267,686	1
2									2
3									3
4									4
5									5
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8									8
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32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 10,119,318	\$ 342,756		\$ 340,394	\$ (2,362)	\$ 5,267,686	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1	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		\$ 10,119,318	\$ 342,756		\$ 340,394	\$ (2,362)	\$ 5,267,686	1
2								2
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28								28
29								29
30								30
31								31
32								32
33								33
34	TOTAL (lines 1 thru 33)	\$ 10,119,318	\$ 342,756		\$ 340,394	\$ (2,362)	\$ 5,267,686	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

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 12M, Carried Forward		\$ 10,119,318	\$ 342,756		\$ 340,394	\$ (2,362)	\$ 5,267,686	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
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28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 10,119,318	\$ 342,756		\$ 340,394	\$ (2,362)	\$ 5,267,686	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1	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		\$ 10,119,318	\$ 342,756		\$ 340,394	\$ (2,362)	\$ 5,267,686	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)	\$ 10,119,318	\$ 342,756		\$ 340,394	\$ (2,362)	\$ 5,267,686	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

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 12O, Carried Forward		\$ 10,119,318	\$ 342,756		\$ 340,394	\$ (2,362)	\$ 5,267,686	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)		\$ 10,119,318	\$ 342,756		\$ 340,394	\$ (2,362)	\$ 5,267,686	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

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 12P, Carried Forward	\$ 10,119,318	\$ 342,756		\$ 340,394	\$ (2,362)	\$ 5,267,686		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)	\$ 10,119,318	\$ 342,756		\$ 340,394	\$ (2,362)	\$ 5,267,686		34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR OHF 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					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
Improvement Type**											
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number P A Peterson Center for Health

0021238

Report Period Beginning:

07/01/05

Ending:

06/30/06

XI. OWNERSHIP COSTS (continued)

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

1	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		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67								67
68								68
69								69
70	TOTAL (lines 4 thru 69)	\$	\$		\$	\$	\$	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR OHF 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					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
Improvement Type**											
9		Management Assets - Security System		1999	60,008		10	6,001	6,001	48,008	9
10		Allocate LSSI				45,262			(45,262)		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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number P A Peterson Center for Health

0021238

Report Period Beginning:

07/01/05

Ending:

06/30/06

XI. OWNERSHIP COSTS (continued)

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

1	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		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67								67
68								68
69								69
70	TOTAL (lines 4 thru 69)	\$	\$		\$	\$	\$	70
		60,008	45,262		6,001	(39,261)	48,008	

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number P A Peterson Center for Health # 0021238 Report Period Beginning: 07/01/05 Ending: 06/30/06

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	\$ 2,052,308	\$ 160,710	\$ 205,231	\$ 44,521	10	\$ 779,734	71
72	Current Year Purchases	39,794	3,871	3,979	108	10	3,979	72
73	Fully Depreciated Assets	741,510				10	741,510	73
74								74
75	TOTALS	\$ 2,833,612	\$ 164,581	\$ 209,210	\$ 44,629		\$ 1,525,223	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	Facility	Handicapped Bus 1991	1991	\$ 38,800	\$	\$	\$	5	\$ 38,800	76
77										77
78										78
79										79
80	TOTALS			\$ 38,800	\$	\$	\$		\$ 38,800	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)	\$ 13,000,185	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 507,337	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 549,604	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 42,267	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 6,831,709	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	95 Improvement CORF - 1995	\$ 30,219	\$	\$	86
87	Dodge Van - 1997	17,032			87
88	Management Autos - 1900	2,495			88
89					89
90					90
91	TOTALS	\$ 49,746	\$	\$	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.

SEE ACCOUNTANTS' COMPILATION REPORT

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	Allocate LSSI				47,365			5
6								6
7	TOTAL				\$ 47,365			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.	_____ /2007	\$ _____
13.	_____ /2008	\$ _____
14.	_____ /2009	\$ _____

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: \$ 9,877 Description: See Attached Schedule

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Allocate LSSI		\$	\$ 355	17
18					18
19					19
20					20
21	TOTAL		\$	\$ 355	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>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <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>2. <u>CLASSROOM PORTION:</u></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>3. <u>CLINICAL PORTION:</u></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	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

- (e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
 - (f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.
- SEE ACCOUNTANTS' COMPILATION REPORT

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

	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	\$		\$ 559,851	\$		\$ 559,851	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			76,488			76,488	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			941,417			941,417	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 prescripts				370,543		370,543	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): See Supplemental					48,312	188,327		236,639	13
14	TOTAL			\$		\$ 1,626,068	\$ 558,870		\$ 2,184,938	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number P A Peterson Center for Health# 0021238Report Period Beginning: 07/01/05

Ending:

06/30/06**XV. BALANCE SHEET - Unrestricted Operating Fund.**As of 06/30/06

(last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)			3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Attached Schedule			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost			16
17	Accumulated Depreciation (book methods)			17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See Attached Schedule			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 856,908	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable			30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached Schedule			36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 856,908	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Attached Schedule			43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 856,908	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ (856,908)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$	\$	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(856,908)	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)	\$ (856,908)	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)	\$ (856,908)	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number P A Peterson Center for Health# 0021238Report Period Beginning: 07/01/05Ending: 06/30/06**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	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 9,956,237	1
2	Discounts and Allowances for all Levels	(252,492)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 9,703,745	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	432,226	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 432,226	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	2,600	13
14	Non-Patient Meals	7,989	14
15	Telephone, Television and Radio	20,033	15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	5,304	20
21	Other Medical Services	113,349	21
22	Laundry	20,529	22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 169,804	23
D. Non-Operating Revenue			
24	Contributions	1,026	24
25	Interest and Other Investment Income***	277	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 1,303	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>See Supplemental Schedule</u>	24,368	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 24,368	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 10,331,446	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	1,582,718	31
32	Health Care	3,407,488	32
33	General Administration	3,072,595	33
B. Capital Expense			
34	Ownership	842,598	34
C. Ancillary Expense			
35	Special Cost Centers	2,216,115	35
36	Provider Participation Fee	66,840	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 11,188,354	40
41	Income before Income Taxes (line 30 minus line 40)**	(856,908)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (856,908)	43

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

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

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

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

Facility Name & ID Number P A Peterson Center for Health

0021238

Report Period Beginning: 07/01/05

Ending: 06/30/06

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	2,412	2,672	\$ 106,008	\$ 39.67	1
2	Assistant Director of Nursing	10,017	11,265	169,651	15.06	2
3	Registered Nurses	36,245	39,650	974,611	24.58	3
4	Licensed Practical Nurses	35,755	38,651	790,341	20.45	4
5	CNAs & Orderlies	81,960	87,418	942,201	10.78	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	6,000	6,847	147,973	21.61	9
10	Activity Assistants					10
11	Social Service Workers	3,392	3,769	53,307	14.14	11
12	Dietician					12
13	Food Service Supervisor	7,847	8,683	106,638	12.28	13
14	Head Cook	7,109	7,478	69,678	9.32	14
15	Cook Helpers/Assistants	27,363	29,193	226,714	7.77	15
16	Dishwashers					16
17	Maintenance Workers	5,316	6,213	111,232	17.90	17
18	Housekeepers	14,911	16,554	126,762	7.66	18
19	Laundry					19
20	Administrator					20
21	Assistant Administrator					21
22	Other Administrative	1,647	1,840	71,774	39.01	22
23	Office Manager	1,448	1,704	32,869	19.29	23
24	Clerical	6,357	6,935	71,294	10.28	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	9,105	9,936	102,187	10.28	31
32	Other Health Care(specify)					32
33	Other(specify) <u>See Supplemental</u>	4,180	4,640	88,188	19.01	33
34	TOTAL (lines 1 - 33)	261,064	283,448	\$ 4,191,428 *	\$ 14.79	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	As Needed	\$ 23,013	01-03	35
36	Medical Director	As Needed	16,200	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	As Needed	850	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	As Needed	1,343	12-03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 41,406		49

C. CONTRACT NURSES

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number P A Peterson Center for Health

0021238

Report Period Beginning: 07/01/05

Ending: 06/30/06

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions			
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount			
Peggy J. Holt	Assoc. Exec Dir.	0	\$ 71,774	Workers' Compensation Insurance	\$ 254,603	IDPH License Fee	\$ 1,990			
				Unemployment Compensation Insurance	14,484	Advertising: Employee Recruitment	2,439			
				FICA Taxes	309,184	Health Care Worker Background Check				
				Employee Health Insurance	245,778	(Indicate # of checks performed)				
				Employee Meals		Patient Background Checks				
				Illinois Municipal Retirement Fund (IMRF)*		Advertising	100,530			
				Disability Insurance	7,903	Dues and Subscriptions	8,838			
				Life Insurance	10,674	Allocate LSSI	12,479			
				Pension	243,072					
TOTAL (agree to Schedule V, line 17, col. 1)			\$ 71,774	TOTAL (agree to Schedule V, line 22, col.8)			\$ 1,085,698	TOTAL (agree to Sch. V, line 20, col. 8)		\$ 25,746
(List each licensed administrator separately.)								Less: Public Relations Expense		()
B. Administrative - Other							Non-allowable advertising		(100,530)	
Description			Amount				Yellow page advertising		()	
LSSI - Management Services			\$ 1,039,494							
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 1,039,494	E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**			
(Attach a copy of any management service agreement)				Description			Line #	Amount	Description	Amount
C. Professional Services				Vendor/Payee			Type	Amount	Out-of-State Travel	\$
Kronos Inc.			\$ 2,460	Kronos Inc.			Computer Services	2,460		
Sure Quest Systems			630	Sure Quest Systems			Computer Services	630		
Gary Anderson & Assoc.			1,765	Gary Anderson & Assoc.			Architecture Services	1,765		
Reserve Advisors			1,744	Reserve Advisors			Property Inspection	1,744		
Duane Morris			41,858	Duane Morris			Legal	41,858		
Michigan Peer Review Org.			1,540	Michigan Peer Review Org.			Legal	1,540		
FR&R			31,364	FR&R			Accounting	31,364		
Authority Healthcare Consult.			2,023	Authority Healthcare Consult.			Healthcare Consulting	2,023		
Revere Healthcare			1,300	Revere Healthcare			Healthcare Consulting	1,300		
Clifton Gunderson			18,000	Clifton Gunderson			Accounting	18,000		
TOTAL (agree to Schedule V, line 19, column 3)			\$ 102,684	TOTAL				\$	Seminar Expense	5,752
(If total legal fees exceed \$5,000, attach copy of invoices.)									Allocate LSSI	20,800
									Entertainment Expense	()
									(agree to Sch. V, line 24, col. 8)	
									TOTAL	\$ 26,552

* Attach copy of IMRF notifications
SEE ACCOUNTANTS' COMPILATION REPORT

**See instructions.

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 FY2003	6 FY2004	7 FY2005	8 FY2006	9 FY2007	10 FY2008	11 FY2009	12 FY2010	13 FY2011
1	N/A		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
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13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. LSN - \$5,928
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? _____
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 10 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 29,897 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. \$ 68,925
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? Yes Indicate the amount. \$ 7,989
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? None
d. Have vehicle usage logs been maintained? Yes
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? Yes
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ _____
- (17) Has an audit been performed by an independent certified public accounting firm? Yes
Firm Name: Clifton Gunderson LLP The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? Yes 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.

SEE ACCOUNTANTS' COMPILATION REPORT