

Facility Name & ID Number P A Peterson Center for Health

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

III. STATISTICAL DATA

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

	1	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>127</u>	Skilled (SNF)	<u>127</u>	<u>46,355</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5	<u>32</u>	Sheltered Care (SC)	<u>32</u>	<u>11,680</u>	5
6		ICF/DD 16 or Less			6
7	<u>159</u>	TOTALS	<u>159</u>	<u>58,035</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>8,996</u>	<u>25,721</u>	<u>11,478</u>	<u>46,195</u>	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC		<u>6,426</u>		<u>6,426</u>	12
13	DD 16 OR LESS					13
14	TOTALS	<u>8,996</u>	<u>32,147</u>	<u>11,478</u>	<u>52,621</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 90.67%

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 11,478

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 06/30/07 Fiscal Year: 06/30/07

* 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: 07/01/06 Ending: 06/30/07

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 BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	373,507	45,900	26,190	445,597		445,597	445,597			1
2	Food Purchase		365,907		365,907		365,907	(12,877)	353,030		2
3	Housekeeping	136,631	30,082		166,713		166,713		166,713		3
4	Laundry		2,385	188,408	190,793		190,793		190,793		4
5	Heat and Other Utilities			235,881	235,881		235,881	1,864	237,745		5
6	Maintenance	118,682	37,744	170,270	326,696		326,696	(12,856)	313,840		6
7	Other (specify):*							1,686	1,686		7
8	TOTAL General Services	628,820	482,018	620,749	1,731,587		1,731,587	(22,183)	1,709,404		8
	B. Health Care and Programs										
9	Medical Director			12,000	12,000		12,000		12,000		9
10	Nursing and Medical Records	3,280,085	52,629	539	3,333,253		3,333,253		3,333,253		10
10a	Therapy										10a
11	Activities	197,029	7,679		204,708		204,708		204,708		11
12	Social Services	85,024		2,921	87,945		87,945		87,945		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	3,562,138	60,308	15,460	3,637,906		3,637,906		3,637,906		16
	C. General Administration										
17	Administrative	78,358		1,057,354	1,135,712		1,135,712	(706,519)	429,193		17
18	Directors Fees										18
19	Professional Services			87,331	87,331		87,331	99,620	186,951		19
20	Dues, Fees, Subscriptions & Promotions			109,580	109,580		109,580	(68,296)	41,284		20
21	Clerical & General Office Expenses	246,171	26,004	149,375	421,550		421,550	219,247	640,797		21
22	Employee Benefits & Payroll Taxes			960,813	960,813		960,813		960,813		22
23	Inservice Training & Education										23
24	Travel and Seminar			10,579	10,579		10,579	15,941	26,520		24
25	Other Admin. Staff Transportation			13,657	13,657		13,657	12,656	26,313		25
26	Insurance-Prop.Liab.Malpractice			326,181	326,181		326,181	28,221	354,402		26
27	Other (specify):*							132,701	132,701		27
28	TOTAL General Administration	324,529	26,004	2,714,870	3,065,403		3,065,403	(266,429)	2,798,974		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,515,487	568,330	3,351,079	8,434,896		8,434,896	(288,612)	8,146,284		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: 07/01/06 Ending: 06/30/07

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclassification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	D. Ownership										
30	Depreciation			514,602	514,602	514,602	95,693	610,295			30
31	Amortization of Pre-Op. & Org.										31
32	Interest			242,588	242,588	242,588	29,047	271,635			32
33	Real Estate Taxes			149,868	149,868	149,868		149,868			33
34	Rent-Facility & Grounds						44,691	44,691			34
35	Rent-Equipment & Vehicles			10,265	10,265	10,265	2,481	12,746			35
36	Other (specify):*			36,617	36,617	36,617		36,617			36
37	TOTAL Ownership			953,940	953,940	953,940	171,912	1,125,852			37
	Ancillary Expense										
	E. Special Cost Centers										
38	Medically Necessary Transportation										38
39	Ancillary Service Centers		636,204	1,355,428	1,991,632	1,991,632		1,991,632			39
40	Barber and Beauty Shops										40
41	Coffee and Gift Shops										41
42	Provider Participation Fee			73,401	73,401	73,401	(3,869)	69,532			42
43	Other (specify):*	3,450			3,450	3,450	(3,450)				43
44	TOTAL Special Cost Centers	3,450	636,204	1,428,829	2,068,483	2,068,483	(7,319)	2,061,164			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	4,518,937	1,204,534	5,733,848	11,457,319	11,457,319	(124,019)	11,333,300			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: 07/01/06

Ending: 06/30/07

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	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(12,877)	02		4
5	Telephone, TV & Radio in Resident Rooms	(25,908)	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	32,833	30		9
10	Interest and Other Investment Income				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	(82,950)	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	(35,120)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (124,022)		\$	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)	3		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 3		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (124,019)		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	Finance Charge	\$ (75)	21	1
2	Marketing Professions	(3,450)	43	2
3	Capitalized R & M	(27,204)	06	3
4	Excess Bad Tax	(3,869)	42	4
5	Non-Allowable Legal	(523)	19	5
6				6
7				7
8				8
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11				11
12				12
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99				99
100				100
101	Total	(35,120)		101

STATE OF ILLINOIS

Summary A

Facility Name & ID Number P A Peterson Center for Health

0021238

Report Period Beginning:

07/01/06

Ending:

06/30/07

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	(12,877)											(12,877)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities			1,832	32								1,864	5
6	Maintenance	(27,204)		14,237	111								(12,856)	6
7	Other (specify):*			1,659	27								1,686	7
8	TOTAL General Services	(40,081)		17,728	170								(22,183)	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			(324,135)	(203,237)	(179,147)							(706,519)	17
18	Directors Fees													18
19	Professional Services	(522)		53,147	28,622	18,373							99,620	19
20	Fees, Subscriptions & Promotions	(82,950)		2,984	11,448	222							(68,296)	20
21	Clerical & General Office Expenses	(25,983)		26,297	119,702	99,231							219,247	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar			14,255	1,104	582							15,941	24
25	Other Admin. Staff Transportation			6,571	2,307	3,778							12,656	25
26	Insurance-Prop.Liab.Malpractice			26,799	536	886							28,221	26
27	Other (specify):*			68,412	24,445	39,844							132,701	27
28	TOTAL General Administration	(109,455)		(125,670)	(15,073)	(16,231)							(266,429)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(149,536)		(107,942)	(14,903)	(16,231)							(288,612)	29

STATE OF ILLINOIS

Facility Name & ID Number P A Peterson Center for Health

0021238

Report Period Beginning:

07/01/06 Ending:

Summary B

06/30/07

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	32,833		52,559	10,295	6							95,693	30
31	Amortization of Pre-Op. & Org.													31
32	Interest			11,832	1,264	15,951							29,047	32
33	Real Estate Taxes													33
34	Rent-Facility & Grounds			42,631	2,060								44,691	34
35	Rent-Equipment & Vehicles			919	1,285	277							2,481	35
36	Other (specify):*													36
37	TOTAL Ownership	32,833		107,941	14,904	16,234							171,912	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	(3,869)											(3,869)	42
43	Other (specify):*	(3,450)											(3,450)	43
44	TOTAL Special Cost Centers	(7,319)											(7,319)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(124,022)		(1)	1	3							(124,019)	45

Facility Name & ID Number P A Peterson Center for Health

0021238

Report Period Beginning:

07/01/06

Ending:

06/30/07

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		\$			\$	\$	1
2	V							2
3	V							3
4	V							4
5	V							5
6	V							6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$			\$	\$ *	14

* 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: 07/01/06 Ending: 06/30/07

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 - Management Allocation	100.00%	\$ 350,837	\$ 350,837	15
16	V	27 Empl Benefits & Taxes		Lutheran Social Services of Illinois - Management Allocation	100.00%	68,497	68,497	16
17	V	19 Prof Fees & Contracts		Lutheran Social Services of Illinois - Management Allocation	100.00%	53,147	53,147	17
18	V	21 Supplies, Telephone,		Lutheran Social Services of Illinois - Management Allocation	100.00%	25,887	25,887	18
19	V	34 Rental of Space		Lutheran Social Services of Illinois - Management Allocation	100.00%	42,631	42,631	19
20	V	5 Utilities		Lutheran Social Services of Illinois - Management Allocation	100.00%	1,832	1,832	20
21	V	6 Bldg Repairs & Maintenance		Lutheran Social Services of Illinois - Management Allocation	100.00%	586	586	21
22	V	32 Interest		Lutheran Social Services of Illinois - Management Allocation	100.00%	11,832	11,832	22
23	V	33 Real Estate Taxes		Lutheran Social Services of Illinois - Management Allocation	100.00%			23
24	V	26 Insurance		Lutheran Social Services of Illinois - Management Allocation	100.00%	26,799	26,799	24
25	V	27 Advertising & Promotions		Lutheran Social Services of Illinois - Management Allocation	100.00%	(85)	(85)	25
26	V	25 Transportation		Lutheran Social Services of Illinois - Management Allocation	100.00%	6,571	6,571	26
27	V	35 Car Rental		Lutheran Social Services of Illinois - Management Allocation	100.00%	233	233	27
28	V	24 Conferences & Conventions		Lutheran Social Services of Illinois - Management Allocation	100.00%	14,255	14,255	28
29	V	20 Subscriptions, Dues, Awards		Lutheran Social Services of Illinois - Management Allocation	100.00%	2,736	2,736	29
30	V	6 Furniture & Fixtures		Lutheran Social Services of Illinois - Management Allocation	100.00%	44	44	30
31	V	6 Machinery & Equipment		Lutheran Social Services of Illinois - Management Allocation	100.00%			31
32	V	35 Equipment Rental		Lutheran Social Services of Illinois - Management Allocation	100.00%	686	686	32
33	V	6 Equipment Repair & Maint.		Lutheran Social Services of Illinois - Management Allocation	100.00%	13,607	13,607	33
34	V	20 Employee Recruitment		Lutheran Social Services of Illinois - Management Allocation	100.00%	248	248	34
35	V	7 Security & Waste Removal		Lutheran Social Services of Illinois - Management Allocation	100.00%	1,659	1,659	35
36	V	21 All Other Miscellaneous		Lutheran Social Services of Illinois - Management Allocation	100.00%	410	410	36
37	V	30 Depreciation		Lutheran Social Services of Illinois - Management Allocation	100.00%	52,559	52,559	37
38	V	17 Management Fees	674,972	Lutheran Social Services of Illinois - Management Allocation	100.00%		(674,972)	38
39	Total		\$ 674,972			\$ 674,971	\$ *	(1) 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: 07/01/06 Ending: 06/30/07

VII. RELATED PARTIES (continued)

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

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

1 Schedule V	2 Line	3 Cost Per General Ledger		4 Amount	5 Cost to Related Organization		6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item			Name of Related Organization					
15	V	21	Salaries & Wages	\$	Lutheran Social Services of Illinois - Human Resource Alloc.	100.00%	\$ 115,159	\$ 115,159	15	
16	V	27	Empl Benefits & Taxes		Lutheran Social Services of Illinois - Human Resource Alloc.	100.00%	24,445	24,445	16	
17	V	19	Prof Fees & Contracts		Lutheran Social Services of Illinois - Human Resource Alloc.	100.00%	28,622	28,622	17	
18	V	21	Supplies, Telephone,		Lutheran Social Services of Illinois - Human Resource Alloc.	100.00%	4,356	4,356	18	
19	V	34	Rental of Space		Lutheran Social Services of Illinois - Human Resource Alloc.	100.00%	2,060	2,060	19	
20	V	5	Utilities		Lutheran Social Services of Illinois - Human Resource Alloc.	100.00%	32	32	20	
21	V	6	Bldg Repairs & Maintenance		Lutheran Social Services of Illinois - Human Resource Alloc.	100.00%			21	
22	V	32	Interest		Lutheran Social Services of Illinois - Human Resource Alloc.	100.00%	1,264	1,264	22	
23	V	33	Real Estate Taxes		Lutheran Social Services of Illinois - Human Resource Alloc.	100.00%			23	
24	V	26	Insurance		Lutheran Social Services of Illinois - Human Resource Alloc.	100.00%	536	536	24	
25	V	27	Advertising & Promotions		Lutheran Social Services of Illinois - Human Resource Alloc.	100.00%			25	
26	V	25	Transportation		Lutheran Social Services of Illinois - Human Resource Alloc.	100.00%	2,307	2,307	26	
27	V	35	Car Rental		Lutheran Social Services of Illinois - Human Resource Alloc.	100.00%	327	327	27	
28	V	24	Conferences & Conventions		Lutheran Social Services of Illinois - Human Resource Alloc.	100.00%	1,104	1,104	28	
29	V	20	Subscriptions, Dues, Awards		Lutheran Social Services of Illinois - Human Resource Alloc.	100.00%	875	875	29	
30	V	6	Furniture & Fixtures		Lutheran Social Services of Illinois - Human Resource Alloc.	100.00%	21	21	30	
31	V	6	Machinery & Equipment		Lutheran Social Services of Illinois - Human Resource Alloc.	100.00%			31	
32	V	35	Equipment Rental		Lutheran Social Services of Illinois - Human Resource Alloc.	100.00%	958	958	32	
33	V	6	Equipment Repair & Maint.		Lutheran Social Services of Illinois - Human Resource Alloc.	100.00%	90	90	33	
34	V	20	Employee Recruitment		Lutheran Social Services of Illinois - Human Resource Alloc.	100.00%	10,573	10,573	34	
35	V	7	Security & Waste Removal		Lutheran Social Services of Illinois - Human Resource Alloc.	100.00%	27	27	35	
36	V	21	All Other Miscellaneous		Lutheran Social Services of Illinois - Human Resource Alloc.	100.00%	187	187	36	
37	V	30	Depreciation		Lutheran Social Services of Illinois - Human Resource Alloc.	100.00%	10,295	10,295	37	
38	V	17	Management Fees	203,237	Lutheran Social Services of Illinois - Human Resource Alloc.	100.00%		(203,237)	38	
39	Total			\$ 203,237			\$ 203,238	\$ *	1	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: 07/01/06Ending: 06/30/07

VII. RELATED PARTIES (continued)

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

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

1 Schedule V	2 Line	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
		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 - Network Administration	100.00%	\$ 94,600	\$ 94,600	15
16	V	27	Empl Benefits & Taxes		Lutheran Social Services of Illinois - Network Administration	100.00%	39,823	39,823	16
17	V	19	Prof Fees & Contracts		Lutheran Social Services of Illinois - Network Administration	100.00%	18,373	18,373	17
18	V	21	Supplies, Telephone,		Lutheran Social Services of Illinois - Network Administration	100.00%	4,631	4,631	18
19	V	34	Rental of Space		Lutheran Social Services of Illinois - Network Administration	100.00%			19
20	V	5	Utilities		Lutheran Social Services of Illinois - Network Administration	100.00%			20
21	V	6	Bldg Repairs & Maintenance		Lutheran Social Services of Illinois - Network Administration	100.00%			21
22	V	32	Interest		Lutheran Social Services of Illinois - Network Administration	100.00%	15,951	15,951	22
23	V	33	Real Estate Taxes		Lutheran Social Services of Illinois - Network Administration	100.00%			23
24	V	26	Insurance		Lutheran Social Services of Illinois - Network Administration	100.00%	886	886	24
25	V	27	Advertising & Promotions		Lutheran Social Services of Illinois - Network Administration	100.00%	21	21	25
26	V	25	Transportation		Lutheran Social Services of Illinois - Network Administration	100.00%	3,778	3,778	26
27	V	35	Car Rental		Lutheran Social Services of Illinois - Network Administration	100.00%			27
28	V	24	Conferences & Conventions		Lutheran Social Services of Illinois - Network Administration	100.00%	582	582	28
29	V	20	Subscriptions, Dues, Awards		Lutheran Social Services of Illinois - Network Administration	100.00%	222	222	29
30	V	6	Furniture & Fixtures		Lutheran Social Services of Illinois - Network Administration	100.00%			30
31	V	6	Machinery & Equipment		Lutheran Social Services of Illinois - Network Administration	100.00%			31
32	V	35	Equipment Rental		Lutheran Social Services of Illinois - Network Administration	100.00%	277	277	32
33	V	6	Equipment Repair & Maint.		Lutheran Social Services of Illinois - Network Administration	100.00%			33
34	V	20	Employee Recruitment		Lutheran Social Services of Illinois - Network Administration	100.00%			34
35	V	7	Security & Waste Removal		Lutheran Social Services of Illinois - Network Administration	100.00%			35
36	V	21	All Other Miscellaneous		Lutheran Social Services of Illinois - Network Administration	100.00%	6	6	36
37	V	30	Depreciation		Lutheran Social Services of Illinois - Network Administration	100.00%			37
38	V	17	Management Fees	179,147	Lutheran Social Services of Illinois - Network Administration	100.00%		(179,147)	38
39	Total			\$ 179,147			\$ 179,150	\$ *	3

* 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.

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.

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

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									\$		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: 07/01/06

Ending: 06/30/07

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: 07/01/06

Ending: 06/30/07

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	17	Salaries & Wages	34,887,231	258	2,966,136	\$ 2,966,136	4,126,493	\$ 350,837	1
2	27	Empl Benefits & Taxes	34,887,231	258	579,108		4,126,493	68,497	2
3	19	Prof Fees & Contracts	34,887,231	258	449,325		4,126,493	53,147	3
4	21	Supplies, Telephone, Postage, Out. Printing	34,887,231	258	218,860		4,126,493	25,887	4
5	34	Rental of Space	34,887,231	258	360,424		4,126,493	42,631	5
6	5	Utilities	34,887,231	258	15,485		4,126,493	1,832	6
7	6	Bldg Repairs & Maintenance	34,887,231	258	4,958		4,126,493	586	7
8	32	Interest	34,887,231	258	100,037		4,126,493	11,832	8
9	33	Real Estate Taxes	34,887,231	258			4,126,493		9
10	26	Insurance	34,887,231	258	226,571		4,126,493	26,799	10
11	27	Advertising & Promotions	34,887,231	258	(716)		4,126,493	(85)	11
12	25	Transportation	34,887,231	258	55,551		4,126,493	6,571	12
13	35	Car Rental	34,887,231	258	1,971		4,126,493	233	13
14	24	Conferences & Conventions	34,887,231	258	120,514		4,126,493	14,255	14
15	20	Subscriptions, Dues, Awards	34,887,231	258	23,131		4,126,493	2,736	15
16	6	Furniture & Fixtures	34,887,231	258	368		4,126,493	44	16
17	6	Machinery & Equipment	34,887,231	258			4,126,493		17
18	35	Equipment Rental	34,887,231	258	5,800		4,126,493	686	18
19	6	Equipment Repair & Maint.	34,887,231	258	115,037		4,126,493	13,607	19
20	20	Employee Recruitment	34,887,231	258	2,093		4,126,493	248	20
21	7	Security & Waste Removal	34,887,231	258	14,026		4,126,493	1,659	21
22	21	All Other Miscellaneous	34,887,231	258	3,470		4,126,493	410	22
23	30	Depreciation	34,887,231	258	444,356		4,126,493	52,559	23
24	TOTALS				\$ 5,706,505	\$ 2,966,136		\$ 674,971	24

SEE ACCOUNTANTS' COMPILATION REPORT

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

Report Period Beginning:

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

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	Salaries & Benefits	54,519,046	248	\$ 1,145,735	\$ 1,145,735	5,479,768	\$ 115,159	1
2	27	Empl Benefits & Taxes		54,519,046	248	243,207	5,479,768	24,445		2
3	19	Prof Fees & Contracts		54,519,046	248	284,768	5,479,768	28,622		3
4	21	Supplies, Telephone,		54,519,046	248		5,479,768			4
5		Postage, Out. Printing		54,519,046	248	43,334	5,479,768	4,356		5
6	34	Rental of Space		54,519,046	248	20,492	5,479,768	2,060		6
7	5	Utilities		54,519,046	248	323	5,479,768	32		7
8	6	Bldg Repairs & Maintenance		54,519,046	248		5,479,768			8
9	32	Interest		54,519,046	248	12,571	5,479,768	1,264		9
10	33	Real Estate Taxes		54,519,046	248		5,479,768			10
11	26	Insurance		54,519,046	248	5,337	5,479,768	536		11
12	27	Advertising & Promotions		54,519,046	248		5,479,768			12
13	25	Transportation		54,519,046	248	22,951	5,479,768	2,307		13
14	35	Car Rental		54,519,046	248	3,249	5,479,768	327		14
15	24	Conferences & Conventions		54,519,046	248	10,979	5,479,768	1,104		15
16	20	Subscriptions, Dues, Awards		54,519,046	248	8,702	5,479,768	875		16
17	6	Furniture & Fixtures		54,519,046	248	204	5,479,768	21		17
18	6	Machinery & Equipment		54,519,046	248		5,479,768			18
19	35	Equipment Rental		54,519,046	248	9,528	5,479,768	958		19
20	6	Equipment Repair & Maint.		54,519,046	248	900	5,479,768	90		20
21	20	Employee Recruitment		54,519,046	248	105,195	5,479,768	10,573		21
22	7	Security & Waste Removal		54,519,046	248	267	5,479,768	27		22
23	21	All Other Miscellaneous		54,519,046	248	1,864	5,479,768	187		23
24	30	Depreciation		54,519,046	248	102,428	5,479,768	10,295		24
25	TOTALS					\$ 2,022,034	\$ 1,145,735		\$ 203,238	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number P A Peterson Center for Health

0021238

Report Period Beginning: 07/01/06

Ending: 06/30/07

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	7,233,218	2	\$ 165,822	\$ 165,822	4,126,493	\$ 94,600	1
2	27	Empl Benefits & Taxes	7,233,218	2	69,804		4,126,493	39,823	2
3	19	Prof Fees & Contracts	7,233,218	2	32,205		4,126,493	18,373	3
4	21	Supplies, Telephone,	7,233,218	2	8,117		4,126,493	4,631	4
5		Postage, Out. Printing	7,233,218	2			4,126,493		5
6	34	Rental of Space	7,233,218	2			4,126,493		6
7	5	Utilities	7,233,218	2			4,126,493		7
8	6	Bldg Repairs & Maintenance	7,233,218	2			4,126,493		8
9	32	Interest	7,233,218	2	27,960		4,126,493	15,951	9
10	33	Real Estate Taxes	7,233,218	2			4,126,493		10
11	26	Insurance	7,233,218	2	1,553		4,126,493	886	11
12	27	Advertising & Promotions	7,233,218	2	37		4,126,493	21	12
13	25	Transportation	7,233,218	2	6,623		4,126,493	3,778	13
14	35	Car Rental	7,233,218	2			4,126,493		14
15	24	Conferences & Conventions	7,233,218	2	1,021		4,126,493	582	15
16	20	Subscriptions, Dues, Awards	7,233,218	2	390		4,126,493	222	16
17	6	Furniture & Fixtures	7,233,218	2			4,126,493		17
18	6	Machinery & Equipment	7,233,218	2			4,126,493		18
19	35	Equipment Rental	7,233,218	2	486		4,126,493	277	19
20	6	Equipment Repair & Maint.	7,233,218	2			4,126,493		20
21	20	Employee Recruitment	7,233,218	2			4,126,493		21
22	7	Security & Waste Removal	7,233,218	2			4,126,493		22
23	21	All Other Miscellaneous	7,233,218	2			4,126,493		23
24	30	Depreciation	7,233,218	2	10		4,126,493	6	24
25	TOTALS				\$ 314,028	\$ 165,822		\$ 179,150	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number P A Peterson Center for Health

0021238

Report Period Beginning: 07/01/06

Ending: 06/30/07

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: 07/01/06

Ending: 06/30/07

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: 07/01/06

Ending: 06/30/07

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: 07/01/06

Ending: 06/30/07

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

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: 07/01/06

Ending: 06/30/07

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	2	3	4	5	6	7	8	9	10											
										Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
											YES	NO				Original	Balance			
A. Directly Facility Related																				
Long-Term																				
1	Tax Exempt Bonds		X	Refinance of 1993 Bonds -		02/16/06	\$ 4,388,000	\$ 4,306,822	02/16/28	0.0523	\$ 242,588	1								
2				Refinance Building Additions								2								
3												3								
4												4								
5	See Supplemental Schedule											5								
Working Capital																				
6	Allocate LSSI		X								29,047	6								
7												7								
8	See Supplemental Schedule											8								
9	TOTAL Facility Related						\$ 4,388,000	\$ 4,306,822			\$ 271,635	9								
B. Non-Facility Related*																				
10												10								
11												11								
12												12								
13	See Supplemental Schedule											13								
14	TOTAL Non-Facility Related						\$	\$			\$	14								
15	TOTALS (line 9+line14)						\$ 4,388,000	\$ 4,306,822			\$ 271,635	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:

07/01/06

Ending:

06/30/07

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.)

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

B. Real Estate Taxes

<p>Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.</p>																																				
1. Real Estate Tax accrual used on 2006 report.		\$ 148,128	1																																	
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		\$ 147,236	2																																	
3. Under or (over) accrual (line 2 minus line 1).		\$ (892)	3																																	
4. Real Estate Tax accrual used for 2007 report. (Detail and explain your calculation of this accrual on the lines below.)		\$ 150,760	4																																	
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$	5																																	
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$	6																																	
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$ 149,868	7																																	
Real Estate Tax History:																																				
Real Estate Tax Bill for Calendar Year:	<table border="1"> <tr><td>2002</td><td>128,164</td><td>8</td></tr> <tr><td>2003</td><td>130,278</td><td>9</td></tr> <tr><td>2004</td><td>138,118</td><td>10</td></tr> <tr><td>2005</td><td>145,939</td><td>11</td></tr> <tr><td>2006</td><td>148,532</td><td>12</td></tr> </table>	2002	128,164	8	2003	130,278	9	2004	138,118	10	2005	145,939	11	2006	148,532	12	<table border="1"> <tr><td colspan="2">FOR BHF USE ONLY</td><td></td></tr> <tr><td>13</td><td>FROM R. E. TAX STATEMENT FOR 2006</td><td>\$</td><td>13</td></tr> <tr><td>14</td><td>PLUS APPEAL COST FROM LINE 5</td><td>\$</td><td>14</td></tr> <tr><td>15</td><td>LESS REFUND FROM LINE 6</td><td>\$</td><td>15</td></tr> <tr><td>16</td><td>AMOUNT TO USE FOR RATE CALCULATION</td><td>\$</td><td>16</td></tr> </table>	FOR BHF USE ONLY			13	FROM R. E. TAX STATEMENT FOR 2006	\$	13	14	PLUS APPEAL COST FROM LINE 5	\$	14	15	LESS REFUND FROM LINE 6	\$	15	16	AMOUNT TO USE FOR RATE CALCULATION	\$	16
2002	128,164	8																																		
2003	130,278	9																																		
2004	138,118	10																																		
2005	145,939	11																																		
2006	148,532	12																																		
FOR BHF USE ONLY																																				
13	FROM R. E. TAX STATEMENT FOR 2006	\$	13																																	
14	PLUS APPEAL COST FROM LINE 5	\$	14																																	
15	LESS REFUND FROM LINE 6	\$	15																																	
16	AMOUNT TO USE FOR RATE CALCULATION	\$	16																																	
Line 2: Payment is 2nd Half of 2005 -\$72,970 and 1st Half of 2006 - \$74,266																																				
Ending Accruals per Client Records																																				

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

SEE ACCOUNTANTS' COMPILATION REPORT

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2006 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 2006 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2006.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2006 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 2007 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.

2006 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 2006 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 2006.

(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>\$ 148,532.24</u>	<u>\$ 148,532.24</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
	TOTALS	\$ 148,532.24	\$ 148,532.24

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 2006 tax bills which were listed in Section A to this statement. Be sure to use the 2006 tax bill which is normally paid during 2007.

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:

07/01/06 Ending:

06/30/07

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

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)	3,917,262	5
6											6
7											7
8											8
Improvement Type**											
9	Various		1969	1969	5,300		20			5,300	9
10	Various		1975	1975	9,226		20			9,226	10
11	Various		1977	1977	10,074		20			10,074	11
12	Various		1980	1980	71,947		20	144	144	71,193	12
13	Various		1981	1981	7,309		20			7,309	13
14	Various		1982	1982	6,151		20			6,151	14
15	Various		1983	1983	30,936		20			30,936	15
16	Various		1984	1984	15,554		20			15,554	16
17	Various		1985	1985	4,850		20			4,850	17
18	Various		1986	1986	21,640		20			21,640	18
19	Various		1988	1988	18,312		20			18,312	19
20	Various		1989	1989	71,006		20			71,006	20
21	Various		1990	1990	104,815		20	5,031	5,031	74,172	21
22	Various		1991	1991	64,328		20			64,328	22
23	Various		1992	1992	20,528		20			20,528	23
24	Various		1993	1993	18,315		20			18,315	24
25	Various		1994	1994	86,971		20			86,971	25
26	Various		1995	1995	780,081		20	30,034	30,034	464,283	26
27	Various		1997	1997	2,685		20	134	134	2,429	27
28	Various		1998	1998	149,521		20	7,476	7,476	96,101	28
29	Various		1999	1999	22,062		20	1,103	1,103	18,217	29
30	Various		2000	2000	63,500		20	3,175	3,175	19,241	30
31	Various		2001	2001	170,563		20	8,528	8,528	65,958	31
32	Various		2002	2002	79,186		20	3,959	3,959	35,395	32
33	Various		2003	2003	166,930		20	8,347	8,347	56,074	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:

07/01/06

Ending:

06/30/07

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
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66								66
67								67
68		60,008			6,001	6,001	48,008	68
69			437,473			(437,473)		69
70		\$ 7,754,578	\$ 577,462		\$ 213,855	\$ (363,607)	\$ 5,354,690	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:

07/01/06

Ending:

06/30/07

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		\$ 7,754,578	\$ 577,462		\$ 213,855	\$ (363,607)	\$ 5,354,690	1
2	Emergency Plumbing- Hot Water	2004	5,048		20	252	252	1,030	2
3	Emergency Plumbing- Hot Water	2004	465		20	23	23	95	3
4	Emergency Outlet Circuits	2004	4,575		20	229	229	648	4
5	Piston Repair For Elevator- Cylinder	2005	8,061		20	403	403	1,088	5
6	Emergency Plumbing- Architect	2005	285		20	14	14	30	6
7	Corner Guards, Wall Sconces, Carpet, Kick Plate	2005	4,507		20	225	225	470	7
8	Piston Replacement For Elevator	2005	1,064		20	53	53	125	8
9	Piston Replacement For Elevator	2005	24,182		20	1,209	1,209	2,858	9
10	Ground Floor- Payment On Chairs, Cubicles, Etc	2005	10,959		20	548	548	1,224	10
11	Hvac Architect Fees Copies& Drafting	2005	2,423		20	121	121	270	11
12	Fire Damper Remodeling Project	2005	115,128		20	5,756	5,756	11,702	12
13	Installation Of Fire Dampers	2005	63,740		20	3,187	3,187	6,479	13
14	Window & Air- Fitness Center & Computer Room	2005	73,833		20	3,692	3,692	7,504	14
15	Hvac Rehab- First Floor	2005	76,077		20	3,804	3,804	7,991	15
16	Hvac Rehab- First Floor	2005	82,560		20	4,128	4,128	8,392	16
17	Drafter & Contracts On Hvac	2005	1,550		20	78	78	155	17
18	Copies & Plots On Hvac	2005	4,869		20	243	243	487	18
19	Boiler- Hot Water Valve, Motor, & Ignitor	2005	12,512		20	626	626	1,251	19
20	Hvac, Drafter	2005	2,812		20	141	141	281	20
21	Hvac Rehab- First Floor	2005	27,866		20	1,393	1,393	2,787	21
22	Norstar- Shear& Install 2 Pieces 48X48 Galvanized	2005	3,465		20	173	173	346	22
23	Installation Of Fire Dampers	2005	20,473		20	1,024	1,024	2,047	23
24	Installation Of Fire Dampers	2005	140,671		20	7,034	7,034	14,067	24
25	Landscaping And Design	2005	2,031		20	102	102	203	25
26	Lcn Door Holders/ Closers For Residents' Rooms	2005	5,520		20	276	276	552	26
27	Ventillation Upgrades- Hvac	2005	33,745		20	1,687	1,687	3,375	27
28	Ventillation Upgrade- Hvac	2005	160,919		20	8,046	8,046	16,092	28
29	Installation Of Fire Dampers	2005	84,247		20	4,212	4,212	8,425	29
30	Ventillation Upgrades- Hvac	2005	101,065		20	5,053	5,053	10,106	30
31	Drywall, Taping, Fire Cauking, Sidewalk, Wiring	2005	59,936		20	2,997	2,997	5,994	31
32	Parking Lot Landscaping And Rehabilitation	2005	1,231		20	62	62	123	32
33	Sidewalk Sections	2005	6,461		20	323	323	646	33
34	TOTAL (lines 1 thru 33)		\$ 8,896,858	\$ 577,462		\$ 270,969	\$ (306,493)	\$ 5,471,532	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:

07/01/06

Ending:

06/30/07

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		\$ 8,896,858	\$ 577,462		\$ 270,969	\$ (306,493)	\$ 5,471,532	1
2	Skilled Medicare Room- Drafter	2005	8,819		20	441	441	882	2
3	Review Water Supply	2005	191		20	10	10	19	3
4	Skilled Medicare Room-Reports & Contracts	2005	315		20	16	16	32	4
5	Sprinkler System& City Code	2005	1,675		20	84	84	168	5
6	First Floor Electrical & Hvac	2005	2,058		20	103	103	206	6
7	Hvac Architect Fees- Plan Review	2005	2,400		20	120	120	240	7
8	Carpet & Paint Samples	2005	2,470		20	123	123	247	8
9	Duane Morris, Bed Conversion	2005	3,383		20	169	169	338	9
10	Hvac Survey	2005	5,461		20	273	273	546	10
11	Hvac Rehab- First Floor	2005	6,803		20	340	340	680	11
12	Pa Peterson -Hvac Project Rvw -Fee	2005	8,695		20	435	435	870	12
13	Fire Damper	2005	13,472		20	674	674	1,347	13
14	1St Floor Electrical & Hvac	2005	18,287		20	914	914	1,829	14
15	Hvac Electrical, & Ventillation	2005	25,455		20	1,273	1,273	2,546	15
16	Remodel Fire Dampers	2005	56,719		20	2,836	2,836	5,672	16
17	Hvac Rehab- First Floor	2005	74,393		20	3,720	3,720	7,439	17
18	Fire Damper Project Pa Peterson	2005	80,909		20	4,045	4,045	8,091	18
19	Ventilation Upgrades- Hvac	2005	103,120		20	5,156	5,156	10,312	19
20	Hvac & Electrical Systems	2005	122,767		20	6,138	6,138	12,277	20
21	Ventilation Upgrades- Hvac	2005	148,374		20	7,419	7,419	14,837	21
22	Ventillation Upgrades	2005	244,601		20	12,230	12,230	24,460	22
23	Hvac Upgrade & Fire Damper	2006	61,560		20	3,078	3,078	6,156	23
24	Hvac, Drafter	2006	698		20	35	35	70	24
25	Installation Of Fire Dampers	2006	14,750		20	738	738	1,475	25
26	Fire Dampers	2006	14,823		20	741	741	1,482	26
27	Ventilation Upgrades- Hvac	2006	25,716		20	1,286	1,286	2,572	27
28	Ventilation Upgrades- Hvac	2006	33,058		20	1,653	1,653	3,306	28
29	Extension Of Pole Base In Parking Lot	2006	590		20	30	30	59	29
30	Concrete For Pole Base	2006	84		20	4	4	8	30
31	Relocate Base And Replaced Pole	2006	3,460		20	173	173	346	31
32	Safety Cable Rails In Stairwells	2006	14,700		20	735	735	1,470	32
33	Flooring In 2Nd Floor Dining Room	2006	12,075		20	604	604	1,208	33
34	TOTAL (lines 1 thru 33)		\$ 10,008,741	\$ 577,462		\$ 326,563	\$ (250,899)	\$ 5,582,721	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:

07/01/06

Ending:

06/30/07

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		\$ 10,008,741	\$ 577,462		\$ 326,563	\$ (250,899)	\$ 5,582,721	1
2	Parking Lot Expansion- Additional Parking Spaces	2006	22,475		20	1,124	1,124	2,248	2
3	Penthouse Chase Lighting	2006	650		20	33	33	65	3
4	Commercial Mechanical- Sink Addition	2006	6,160		20	308	308	616	4
5	Parking Lot Pole Replacement	2006	13,300		20	665	665	1,330	5
6	Install Lights To Center Court	2006	24,260		20	1,213	1,213	2,426	6
7	3 Door Alarms For Stairways	2006	3,250		20	163	163	325	7
8	Two Whirlpools	2006	21,339		20	1,067	1,067	2,134	8
9	Two Whirlpool Bathtubs	2006	1,956		20	98	98	196	9
10	Walk-In Cooler Repair	2006	2,887		20	144	144	289	10
11	Repair Fire Protection Main	2006	12,100		20	605	605	1,210	11
12	Landscaping	2006	2,200		20	110	110	220	12
13	Shelter Care Upgrad Rehav Hvac	2006	4,431		20	222	222	222	13
14	Shelter Upgrade To Skilled Medicare	2006	68,942		20	3,447	3,447	3,447	14
15	A/C Repair*	2006	2,561		20	128	128	128	15
16	Boiler Repair*	2006	3,857		20	193	193	193	16
17	3Rd Floor New Flooring	2007	21,341		20	1,067	1,067	1,067	17
18	1St Floor Dinning Rm Flooring	2007	3,598		20	180	180	180	18
19	Phase Iii Hvac & Fire Damper	2007	686,480		20	34,324	34,324	34,324	19
20	Fire Place For Third Floor	2007	2,149		20	107	107	107	20
21	Custom Valance-Lobby Area 2Nd Fl	2007	979		20	49	49	49	21
22	Wall & Window Treatements-3Rd Fl	2007	29,429		20	1,471	1,471	1,471	22
23	Landscaping	2007	9,982		20	499	499	499	23
24	Third Floor New Flooring*	2007	22,224		20	1,111	1,111	1,111	24
25	Recover Awning*	2007	5,790		20	290	290	290	25
26	Repair 3Rd Floor Patio Roof*	2007	1,000		20	50	50	50	26
27	Lobby Carpeting*	2007	10,945		20	547	547	547	27
28	Masonry And Caulking Repairs*	2007	3,835		20	192	192	192	28
29	Masonry And Caulking Repairs*	2007	3,835		20	192	192	192	29
30	New Controller And Thermostat On Chiller*	2007	4,525		20	226	226	226	30
31	Boiler Repair*	2007	4,624		20	231	231	231	31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 11,009,845	\$ 577,462		\$ 376,618	\$ (200,844)	\$ 5,638,305	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		\$ 11,009,845	\$ 577,462		\$ 376,618	\$ (200,844)	\$ 5,638,305	1
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33								33
34	TOTAL (lines 1 thru 33)	\$ 11,009,845	\$ 577,462		\$ 376,618	\$ (200,844)	\$ 5,638,305	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		\$ 11,009,845	\$ 577,462		\$ 376,618	\$ (200,844)	\$ 5,638,305	1
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33								33
34	TOTAL (lines 1 thru 33)	\$ 11,009,845	\$ 577,462		\$ 376,618	\$ (200,844)	\$ 5,638,305	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		\$ 11,009,845	\$ 577,462		\$ 376,618	\$ (200,844)	\$ 5,638,305	1
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33								33
34	TOTAL (lines 1 thru 33)	\$ 11,009,845	\$ 577,462		\$ 376,618	\$ (200,844)	\$ 5,638,305	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		\$ 11,009,845	\$ 577,462		\$ 376,618	\$ (200,844)	\$ 5,638,305	1
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34	TOTAL (lines 1 thru 33)	\$ 11,009,845	\$ 577,462		\$ 376,618	\$ (200,844)	\$ 5,638,305	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		\$ 11,009,845	\$ 577,462		\$ 376,618	\$ (200,844)	\$ 5,638,305	1
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34	TOTAL (lines 1 thru 33)	\$ 11,009,845	\$ 577,462		\$ 376,618	\$ (200,844)	\$ 5,638,305	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		\$ 11,009,845	\$ 577,462		\$ 376,618	\$ (200,844)	\$ 5,638,305	1
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34	TOTAL (lines 1 thru 33)	\$ 11,009,845	\$ 577,462		\$ 376,618	\$ (200,844)	\$ 5,638,305	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	\$ 11,009,845	\$ 577,462		\$ 376,618	\$ (200,844)	\$ 5,638,305		1
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33									33
34	TOTAL (lines 1 thru 33)	\$ 11,009,845	\$ 577,462		\$ 376,618	\$ (200,844)	\$ 5,638,305		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	\$ 11,009,845	\$ 577,462		\$ 376,618	\$ (200,844)	\$ 5,638,305		1
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33									33
34	TOTAL (lines 1 thru 33)	\$ 11,009,845	\$ 577,462		\$ 376,618	\$ (200,844)	\$ 5,638,305		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 12L, Carried Forward	\$ 11,009,845	\$ 577,462		\$ 376,618	\$ (200,844)	\$ 5,638,305		1
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4									4
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33									33
34	TOTAL (lines 1 thru 33)	\$ 11,009,845	\$ 577,462		\$ 376,618	\$ (200,844)	\$ 5,638,305		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		\$ 11,009,845	\$ 577,462		\$ 376,618	\$ (200,844)	\$ 5,638,305	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)	\$ 11,009,845	\$ 577,462		\$ 376,618	\$ (200,844)	\$ 5,638,305	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		\$ 11,009,845	\$ 577,462		\$ 376,618	\$ (200,844)	\$ 5,638,305	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)	\$ 11,009,845	\$ 577,462		\$ 376,618	\$ (200,844)	\$ 5,638,305	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		\$ 11,009,845	\$ 577,462		\$ 376,618	\$ (200,844)	\$ 5,638,305	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)	\$ 11,009,845	\$ 577,462		\$ 376,618	\$ (200,844)	\$ 5,638,305	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	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12P, Carried Forward		\$ 11,009,845	\$ 577,462		\$ 376,618	\$ (200,844)	\$ 5,638,305	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)		\$ 11,009,845	\$ 577,462		\$ 376,618	\$ (200,844)	\$ 5,638,305	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.

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.

Facility Name & ID Number P A Peterson Center for Health

0021238

Report Period Beginning:

07/01/06

Ending:

06/30/07

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		Mangement Assets - Security System		1999	60,008		10	6,001	6,001	48,008	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:

07/01/06

Ending:

06/30/07

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)	\$	60,008	\$		\$	6,001	\$	48,008	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: 07/01/06 Ending: 06/30/07

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	\$ 2,103,942	\$	\$ 210,394	\$ 210,394	10	\$ 994,107	71
72	Current Year Purchases	25,265		3,968	3,968	10	3,968	72
73	Fully Depreciated Assets	741,510				10	741,510	73
74								74
75	TOTALS	\$ 2,870,717	\$	\$ 214,362	\$ 214,362		\$ 1,739,585	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		Handicapped Bus 1991	1991	\$ 38,800	\$	\$	\$	5	\$ 38,800	76
77		2006 Chevy Turtle Top Bus	2006	96,576		19,315	19,315	5	19,315	77
78										78
79										79
80	TOTALS			\$ 135,376	\$	\$ 19,315	\$ 19,315		\$ 58,115	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)	\$ 14,024,393	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 577,462	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 610,295	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 32,833	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 7,436,005	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: _____

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				44,691			5
6					_____			6
7	TOTAL				\$ 44,691			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.	_____ /2008	\$ _____
13.	_____ /2009	\$ _____
14.	_____ /2010	\$ _____

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: \$ 12,186 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		\$ _____	\$ 560	17
18			_____	_____	18
19			_____	_____	19
20			_____	_____	20
21	TOTAL		\$ _____	\$ 560	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	\$		\$ 387,696	\$		\$ 387,696	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			60,617			60,617	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			871,174			871,174	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				446,482		446,482	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					35,941	189,722		225,663	13
14	TOTAL			\$		\$ 1,355,428	\$ 636,204		\$ 1,991,632	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: 07/01/06

Ending:

06/30/07**XV. BALANCE SHEET - Unrestricted Operating Fund.**As of 06/30/07

(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
	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
	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	\$	\$	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
	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$	\$	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
	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$	\$	46
47	TOTAL EQUITY (page 18, line 24)	\$	\$	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)	(92,758)	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)	\$ (92,758)	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)	\$ (92,758)	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number P A Peterson Center for Health

0021238

Report Period Beginning: 07/01/06

Ending: 06/30/07

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	\$ 10,935,293	1
2	Discounts and Allowances for all Levels	(210,789)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 10,724,504	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	532,009	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 532,009	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	2,846	13
14	Non-Patient Meals	10,684	14
15	Telephone, Television and Radio	25,908	15
16	Rental of Facility Space		16
17	Sale of Drugs	2,852	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	7,709	20
21	Other Medical Services	6,422	21
22	Laundry	26,449	22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 82,870	23
D. Non-Operating Revenue			
24	Contributions	850	24
25	Interest and Other Investment Income***	75	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 925	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>See Supplemental Schedule</u>	24,253	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 24,253	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 11,364,561	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	1,731,587	31
32	Health Care	3,637,906	32
33	General Administration	3,065,403	33
B. Capital Expense			
34	Ownership	953,940	34
C. Ancillary Expense			
35	Special Cost Centers	1,995,082	35
36	Provider Participation Fee	73,401	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 11,457,319	40
41	Income before Income Taxes (line 30 minus line 40)**	(92,758)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (92,758)	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:

07/01/06

Ending:

06/30/07

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	2,043	2,460	\$ 93,375	\$ 37.96	1
2	Assistant Director of Nursing	10,292	11,612	177,277	15.27	2
3	Registered Nurses	35,536	38,715	1,015,064	26.22	3
4	Licensed Practical Nurses	34,167	37,317	803,001	21.52	4
5	CNAs & Orderlies	94,421	101,606	1,083,018	10.66	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	9,413	10,572	186,071	17.60	9
10	Activity Assistants					10
11	Social Service Workers	1,802	2,020	34,775	17.22	11
12	Dietician					12
13	Food Service Supervisor	4,292	4,937	86,245	17.47	13
14	Head Cook	7,036	7,495	73,466	9.80	14
15	Cook Helpers/Assistants	26,326	28,324	213,796	7.55	15
16	Dishwashers					16
17	Maintenance Workers	7,303	8,725	118,682	13.60	17
18	Housekeepers	16,559	18,046	136,631	7.57	18
19	Laundry					19
20	Administrator					20
21	Assistant Administrator					21
22	Other Administrative	1,476	1,950	78,358	40.18	22
23	Office Manager	4,083	4,681	78,676	16.81	23
24	Clerical	11,454	12,934	167,495	12.95	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	9,433	10,411	108,350	10.41	31
32	Other Health Care(specify)					32
33	Other(specify) <u>See Supplemental</u>	3,004	3,344	64,657	19.34	33
34	TOTAL (lines 1 - 33)	278,640	305,149	\$ 4,518,937 *	\$ 14.81	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	\$ 26,190	01-03	35
36	Medical Director	As Needed	12,000	09-03	36
37	Medical Records Consultant	As Needed	199	10-03	37
38	Nurse Consultant				38
39	Pharmacist Consultant	As Needed	340	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	2,921	12-03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 41,650		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

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 FY2004	6 FY2005	7 FY2006	8 FY2007	9 FY2008	10 FY2009	11 FY2010	12 FY2011	13 FY2012
1	N/A		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
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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 - \$7,489
- (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 Yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 35,871 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. \$ 69,532
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. \$ 12,877
- (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? No If no, please explain. Not Complete
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? N/A
Attach invoices and a summary of services for all architect and appraisal fees.

SEE ACCOUNTANTS' COMPILATION REPORT