

Facility Name & ID Number PETERSON PARK HEALTH CARE CTR

0024463 Report Period Beginning: 01/01/2007 Ending: 12/31/2007

III. STATISTICAL DATA

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

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

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	<u>7,168</u>	<u>860</u>	<u>4,452</u>	<u>12,480</u>	8
9	SNF/PED					9
10	ICF	<u>47,969</u>	<u>3,438</u>	<u>624</u>	<u>52,031</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>55,137</u>	<u>4,298</u>	<u>5,076</u>	<u>64,511</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 94.01%

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)

NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES NO

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

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

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

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 17 and days of care provided 4,452

Medicare Intermediary ADMINASTAR

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/2007 Fiscal Year: 12/31/2007

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

Facility Name & ID Number **PETERSON PARK HEALTH CARE CTR** # **0024463** Report Period Beginning: **01/01/2007** Ending: **12/31/2007**

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	344,980	29,496	10,183	384,659		384,659		384,659		1
2	Food Purchase		378,107		378,107	(38,106)	340,001	(2,372)	337,629		2
3	Housekeeping	181,493	26,225		207,718		207,718		207,718		3
4	Laundry	84,180	15,745		99,925		99,925		99,925		4
5	Heat and Other Utilities			208,996	208,996		208,996	6,512	215,508		5
6	Maintenance	50,968	9,691	78,118	138,777		138,777	8,527	147,304		6
7	Other (specify):*			12,296	12,296		12,296		12,296		7
8	TOTAL General Services	661,621	459,264	309,593	1,430,478	(38,106)	1,392,372	12,667	1,405,039		8
	B. Health Care and Programs										
9	Medical Director										9
10	Nursing and Medical Records	2,581,339	149,099	21,696	2,752,134		2,752,134		2,752,134		10
10a	Therapy	308,127		270	308,397	(167,242)	141,155		141,155		10a
11	Activities	195,114	26,664	2,574	224,352		224,352		224,352		11
12	Social Services	195,464		4,938	200,402		200,402		200,402		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	3,280,044	175,763	29,478	3,485,285	(167,242)	3,318,043		3,318,043		16
	C. General Administration										
17	Administrative	255,189		605,008	860,197		860,197	(513,792)	346,405		17
18	Directors Fees										18
19	Professional Services			108,009	108,009		108,009	20,232	128,241		19
20	Dues, Fees, Subscriptions & Promotions			101,527	101,527		101,527	(74,110)	27,417		20
21	Clerical & General Office Expenses	157,989	19,667	61,335	238,991		238,991	227,594	466,585		21
22	Employee Benefits & Payroll Taxes			680,808	680,808	38,106	718,914	56,302	775,216		22
23	Inservice Training & Education										23
24	Travel and Seminar			3,845	3,845		3,845		3,845		24
25	Other Admin. Staff Transportation			644	644		644	6,272	6,916		25
26	Insurance-Prop.Liab.Malpractice			12,150	12,150		12,150	174,443	186,593		26
27	Other (specify):*			82,003	82,003		82,003	(78,759)	3,244		27
28	TOTAL General Administration	413,178	19,667	1,655,329	2,088,174	38,106	2,126,280	(181,818)	1,944,462		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,354,843	654,694	1,994,400	7,003,937	(167,242)	6,836,695	(169,151)	6,667,544		29

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

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

V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE	SCHED REF	TOTAL
1	DIETARY	
	DIETITIAN CONSULTANT XVIII B 35-2	10,183
	REPAIRS & MAINTENANCE	0
		0
		10,183
3	HOUSEKEEPING	
		0
		0
		0
4	LAUNDRY	
	EQUIPMENT REPAIRS & MAINTENANCE	0
		0
		0
5	HEAT & OTHER UTILITIES	
	GAS HEAT	111,971
	ELECTRICITY	67,442
	WATER	27,557
	CABLE TV - LOBBY	2,026
		0
		208,996
6	MAINTENANCE	
	GROUNDS MAINTENANCE	0
	PAINTING & DECORATING	0
	BUILDING REPAIRS	1,385
	MAINTENANCE TRAVEL	0
	EQUIPMENT MAINTENANCE & REPAIR	60,417
	ELEVATOR MAINTENANCE & REPAIR	9,946
	OUTSIDE LABOR	0
	EXTERMINATING SERVICE	5,533
	FIRE SERVICE	837
		0
		0
		0
		0
		78,118
7	OTHER	
	SCAVENGER	9,748
	SECURITY SERVICE	2,548
		0
		0
		12,296
9	MEDICAL DIRECTOR	
	MEDICAL DIRECTOR FEES XVIII B 36-2	0
		0

LINE	SCHED REF	TOTAL
10	NURSING	
	CONTRACT NURSING XVIII C 53-2	5,075
	LABORATORY & XRAY EXPENSE	4,868
	PURCHASED SERVICES	0
	PSYCHO-SOCIAL CONSULTANT XVIII B ___-2	0
	RESTORATIVE NURSING CONSULTANT XVIII B 38-2	0
	MEDICAL RECORDS CONSULTANT XVIII B 37-2	3,825
	PHARMACY CONSULTANT XVIII B 39-2	0
	UTILIZATION REVIEW FEES XVIII B ___-2	0
	PHYSICIANS XVIII B ___-2	0
	PSYCHIATRIC XVIII B ___-2	0
	RN CONSULTANT XVIII B 38-2	1,400
	CARE PLAN CONSULTANT	6,528
		0
		21,696
10a	THERAPY	
	PHYSICAL THERAPY SERVICES	0
	SPEECH THERAPY SERVICES	0
	OCCUPATIONAL THERAPY SERVICES	0
	REHABILITATION CONSULTANT XVIII B ___-2	0
	PHYSICAL THERAPY CONSULTANT XVIII B 40-2	270
	OCCUPATIONAL THERAPY CONSULTA XVIII B 41-2	0
	RESPIRATORY THERAPY CONSULTAN XVIII B 42-2	0
	SPEECH THERAPY CONSULTANT XVIII B 43-2	0
		270
11	ACTIVITIES	
	CABLE TV - PATIENT ROOMS	0
	ACTIVITY REHAB CONSULTANT XVIII B 44-2	2,574
		2,574
12	SOCIAL SERVICES	
	SOCIAL REHABILITATION SERVICES	0
	SOCIAL REHABILITATION CONSULTAN XVIII B 45-2	564
	SOCIAL WORKER XVIII B 45-2	4,374
		0
		4,938
13	NURSE AIDE TRAINING	
	NURSE AIDE TRAINING COSTS XIII	0
		0

V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE	SCHED REF	TOTAL
14	PROGRAM TRANSPORTATION	
	PATIENT TRANSPORTATION	0
17	ADMINISTRATIVE	
	MANAGEMENT FEES XIX B	605,008
	DIRECTORS FEES	
18	DIRECTORS FEES	0
19	PROFESSIONAL SERVICES	
	DATA PROCESSING XIX C	37,601
	ADMINISTRATIVE CONSULTANTS XIX C	0
	PROFESSIONAL FEES XIX C	70,408
		0
		108,009
20	FEES,SUBSCRIPTIONS,PROMOTIONS	
	ENTERTAINMENT & MARKETING VI 19 XIX F	0
	ADV & PROMO-NON PATIENT RELATED VI 25 XIX F	66,633
	EMPLOYEE WANT ADS XIX F	9,600
	CONTRIBUTIONS VI 20 XIX F	487
	DUES & SUBSCRIPTIONS XIX F	17,815
	LICENSES & PERMITS XIX F	4,295
	PUBLIC RELATIONS-PATIENT RELATED XIX F	
	ADVERTISING-YELLOW PAGES VI 28 XIX F	937
	TRUST FEES / FRANCHISE TAX / ETC VI 17 XIX F	0
	CONTRIBUTIONS - POLITICAL VI 20 XIX F	0
	HEALTH CARE WORKER BACKGROUND CHEC XIX F	1,760
	PATIENT BACKGROUND CHECKS XIX F	0
		101,527
21	CLERICAL & GENERAL OFFICE EXPENSES	
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)	1,195
	EQUIPMENT REPAIR & MAINTENANCE	0
	OUTSIDE CLERICAL SERVICES	38,515
	PENALTIES / OVERDRAFT CHARGES VI 18	1,359
	HOME OFFICE EXPENSE	0
	THEFT & DAMAGE LOSS	0
	TELEPHONE	20,266
	MESSENGER SERVICE	0
		0
		61,335

LINE	SCHED REF	TOTAL
22	EMPLOYEE BENEFITS & PAYROLL TAXES	
	FICA TAXES XIX D	328,019
	UNEMPLOYMENT COMPENSATION XIX D	47,867
	WORKERS COMPENSATION INSURANC XIX D	84,927
	HOSPITALIZATION INSURANCE XIX D	177,256
	EMPLOYEE BENEFITS - OTHER XIX D	11,030
	EMPLOYEE PHYSICAL EXAMS XIX D	0
	INSURANCE - EXECUTIVE LIFE VI 21/XIX D	668
	PENSION/PROFIT SHARING PLANS XIX D	23,805
	CHICAGO HEAD TAX XIX D	7,236
		0
		680,808
23	INSERVICE TRAINING & EDUCATION	
	EDUCATION & SEMINARS	0
		0
24	TRAVEL & SEMINARS	
	EDUCATION & SEMINARS XIX G	3,845
	TRAVEL XIX G	0
		3,845
25	ADMIN. STAFF TRANSPORTATION	
	TRANSPORTATION - STAFF	644
		644
26	INSURANCE - PROP. LIAB & MALPRACTICE	
	GENERAL INSURANCE	12,150
		12,150
27	OTHER	
	BAD DEBTS VI 24	82,003
		82,003

GRAND TOTAL COLUMN 3 OTHER

1,994,400

**PETERSON PARK HEALTH CARE CTR
SCHEDULES
12/31/2007**

**EMPLOYEE MEAL RECLASSIFICATION
PAGE 3 SCHEDULE V COLUMN 5 LINES 2 AND 22**

TOTAL FOOD PURCHASE	378,107
LESS SALES TAX	<u>(2,372)</u>
NET FOOD	375,735

TOTAL PATIENT CENSUS	64,511
TIME 3 MEALS PER DAY	<u>3</u>
TOTAL PATIENT MEALS	193,533

ADD # EMPLOYEE MEALS/DAY	60
TIME # DAYS	<u>365</u>
TOTAL EMPLOYEE MEALS	21,900

PATIENT MEALS	193,533
ADD EMPLOYEE MEALS	<u>21,900</u>
TOTAL MEALS/YEAR	215,433

NET FOOD	375,735
DIVIDE TOTAL MEALS/YEAR	<u>215,433</u>

COST PER MEAL	1.74
TIME EMPLOYEE MEALS	<u>21,900</u>
EMPLOYEE MEAL RECLASSIFICATION	38,106

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Facility Name & ID Number **PETERSON PARK HEALTH CARE CTR**

#0024463

Report Period Beginning:

01/01/2007

Ending:

12/31/2007

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	D. Ownership										
30	Depreciation							228,182	228,182		30
31	Amortization of Pre-Op. & Org.										31
32	Interest							352,718	352,718		32
33	Real Estate Taxes							213,438	213,438		33
34	Rent-Facility & Grounds			1,094,760	1,094,760		1,094,760	(1,094,760)			34
35	Rent-Equipment & Vehicles			31,363	31,363		31,363		31,363		35
36	Other (specify):*							29,786	29,786		36
37	TOTAL Ownership			1,126,123	1,126,123		1,126,123	(270,636)	855,487		37
	Ancillary Expense										
	E. Special Cost Centers										
38	Medically Necessary Transportation										38
39	Ancillary Service Centers		189,850	33,352	223,202	167,242	390,444		390,444		39
40	Barber and Beauty Shops										40
41	Coffee and Gift Shops										41
42	Provider Participation Fee			102,930	102,930		102,930		102,930		42
43	Other (specify):*										43
44	TOTAL Special Cost Centers		189,850	136,282	326,132	167,242	493,374		493,374		44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	4,354,843	844,544	3,256,805	8,456,192		8,456,192	(439,787)	8,016,405		45

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

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				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	124,900	30		9
10	Interest and Other Investment Income	(30)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(2,372)	2		13
14	Non-Care Related Interest		32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees		20		17
18	Fines and Penalties	(1,359)	21		18
19	Entertainment		20		19
20	Contributions	(487)	20		20
21	Owner or Key-Man Insurance	(668)	22		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(82,003)	27		24
25	Fund Raising, Advertising and Promotional	(66,633)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(937)	20		28
29	Other-Attach Schedule	(6,137)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (35,726)		\$	30

BHF USE ONLY					
48	49	50	51	52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1	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)	(404,061)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (404,061)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (439,787)		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.		X	\$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

PETERSON PARK HEALTH CARE CTR

ID# 0024463

Report Period Beginning: 01/01/2007

Ending: 12/31/2007

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	DEFERRED MAINTENANCE	\$ 398	6	1
2	OUT OF PERIOD DUES & SUBSRIPTIONS	(6,535)	20	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				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(6,137)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number PETERSON PARK HEALTH CARE CTR# 0024463

Report Period Beginning:

01/01/2007

Ending:

12/31/2007

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
		(to Sch V, col.7)												
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(2,372)	0	0	0	0	0	0	0	0	0	0	(2,372)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	6,512	0	0	0	0	0	0	0	0	6,512	5
6	Maintenance	398	0	8,129	0	0	0	0	0	0	0	0	8,527	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(1,974)	0	14,641	0	0	0	0	0	0	0	0	12,667	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	(490,008)	(23,784)	0	0	0	0	0	0	0	(513,792)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	13,725	6,507	0	0	0	0	0	0	0	0	20,232	19
20	Fees, Subscriptions & Promotions	(74,592)	250	232	0	0	0	0	0	0	0	0	(74,110)	20
21	Clerical & General Office Expenses	(1,359)	0	228,953	0	0	0	0	0	0	0	0	227,594	21
22	Employee Benefits & Payroll Taxes	(668)	0	56,970	0	0	0	0	0	0	0	0	56,302	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	6,272	0	0	0	0	0	0	0	0	6,272	25
26	Insurance-Prop.Liab.Malpractice	0	170,701	3,742	0	0	0	0	0	0	0	0	174,443	26
27	Other (specify):*	(82,003)	0	0	3,244	0	0	0	0	0	0	0	(78,759)	27
28	TOTAL General Administration	(158,622)	184,676	(187,332)	(20,540)	0	(181,818)	28						
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(160,596)	184,676	(172,691)	(20,540)	0	(169,151)	29						

STATE OF ILLINOIS

Summary B

Facility Name & ID Number PETERSON PARK HEALTH CARE CTR # 0024463 Report Period Beginning: 01/01/2007 Ending: 12/31/2007

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 TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	124,900	90,189	13,093	0	0	0	0	0	0	0	0	228,182	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(30)	341,896	10,852	0	0	0	0	0	0	0	0	352,718	32
33	Real Estate Taxes	0	200,926	12,512	0	0	0	0	0	0	0	0	213,438	33
34	Rent-Facility & Grounds	0	(1,094,760)	0	0	0	0	0	0	0	0	0	(1,094,760)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	29,786	0	0	0	0	0	0	0	0	0	29,786	36
37	TOTAL Ownership	124,870	(431,963)	36,457	0	0	0	0	0	0	0	0	(270,636)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(35,726)	(247,287)	(136,234)	(20,540)	0	(439,787)	45						

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
<u>LIST ATTACHED</u>		<u>EMBASSY CARE CENTER</u>	<u>WILMINGTON</u>	<u>SEE SCHEDULE</u>		

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)	
1	V	<u>34 RENT</u>	\$ <u>1,094,760</u>	<u>PETERSON PARK REALTY</u>		\$	\$ <u>(1,094,760)</u>	1
2	V	<u>19 PROF. FEES. - ACCOUNTING</u>				<u>5,225</u>	<u>5,225</u>	2
3	V	<u>19 PROF. FEES. -H.U.D. AUDIT</u>				<u>8,500</u>	<u>8,500</u>	3
4	V	<u>33 PROF. FEES - R/E REDUCTION</u>				<u>15,388</u>	<u>15,388</u>	4
5	V	<u>20 LICENSES & FEES</u>				<u>250</u>	<u>250</u>	5
6	V	<u>26 INSURANCE - GENERAL</u>				<u>170,701</u>	<u>170,701</u>	6
7	V	<u>30 DEPRECIATION</u>				<u>90,189</u>	<u>90,189</u>	7
8	V	<u>32 INTEREST</u>				<u>341,896</u>	<u>341,896</u>	8
9	V	<u>33 REAL ESTATE TAXES</u>				<u>185,538</u>	<u>185,538</u>	9
10	V	<u>36 INSURANCE H.U.D. (MIP)</u>				<u>29,786</u>	<u>29,786</u>	10
11	V							11
12	V							12
13	V							13
14	Total		\$ <u>1,094,760</u>			\$ <u>847,473</u>	\$ * <u>(247,287)</u>	14

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	17 MANAGEMENT FEES	\$ 605,008			\$	\$ (605,008)
16	V	5 UTILITIES				6,512	6,512
17	V	6 MAINTENANCE				8,129	8,129
18	V	17 MANAGEMENT FEES				115,000	115,000
19	V	19 PROFESSIONAL FEES				6,507	6,507
20	V	20 LICENSE & FEES				232	232
21	V	21 CLERICAL & GENERAL	38,515			175,138	136,623
22	V	21 OFFICE				56,993	56,993
23	V	21 PAYROLL DIRECT				35,337	35,337
24	V	22 PAYROLL TAX DIRECT				2,818	2,818
25	V	22 EMPLOYEE BENEFITS				54,152	54,152
26	V	25 AUTO EXPENSE				6,272	6,272
27	V	26 INSURANCE				3,742	3,742
28	V	30 DEPRECIATION				13,093	13,093
29	V	32 AMORTIZATION				10,852	10,852
30	V	33 REAL ESTATE TAXES				12,512	12,512
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 643,523			\$ 507,289	\$ * (136,234)

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	17 MANAGEMENT FEE (from future)	\$ 115,000	FUTURE ASSOCIATES		\$	\$ (115,000)
16	V	17 SALARY		SHABAT & ASSOCIATES		91,216	91,216
17	V	27 PAYROLL TAXES		SHABAT & ASSOCIATES		3,244	3,244
18	V						
19	V						
20	V						
21	V						
22	V						
23	V						
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 115,000			\$ 94,460	\$ * (20,540)

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

Facility Name & ID Number PETERSON PARK HEALTH CARE CTR # 0024463 Report Period Beginning: 01/01/2007 Ending: 12/31/2007

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	RONALD SHABAT	Director	Administrative	43.09				SALARY	\$ 54,218	17-1	1
2	RONALD SHABAT	Director	Administrative	43.09				SALARY	91,216	17-7	2
3											3
4	MENACHEM SHABAT			6.38				SALARY	119,721	17-1	4
5											5
6	CHAIM RAJCHENBACH		Adiministrator					SALARY	54,218	17-1	6
7											7
8	NACHSHON DRAIMAN	Director	Administrative	35.64							8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 319,373		13

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

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

Facility Name & ID Number **PETERSON PARK HEALTH CARE CTR**

0024463

Report Period Beginning:

01/01/2007

Ending: **2/31/2007**

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 PETERSON PARKHEALTH CARE REALTY
 Street Address 6141 NORTH PULASKI RD.
 City / State / Zip Code CHICAGO,IL.60646
 Phone Number (773)478-2000
 Fax Number (847)478-8408

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	19	PROF . FEES- ACCOUNTING	DIRECT	1	\$ 5,225	\$ 0	1	\$ 5,225	1
2	19	PROF . FEES- H.U.D. AUDIT	DIRECT	1	8,500	0	1	8,500	2
3	33	PROF . FEES R/E REDUCTION	DIRECT	1	15,388	0	1	15,388	3
4	20	LICENSES & FEES	DIRECT	1	250	0	1	250	4
5	26	INSURANCE - GENERAL	DIRECT	1	170,701	0	1	170,701	5
6	30	DEPRECIATION	DIRECT	1	90,189	0	1	90,189	6
7	32	INTEREST	DIRECT	1	341,896	0	1	341,896	7
8	33	REAL ESTATE TAXES	DIRECT	1	185,538	0	1	185,538	8
9	36	INSURANCE H.U.D. - (MIP)	DIRECT	1	29,786	0	1	29,786	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				\$ 847,473	\$		\$ 847,473	25

Facility Name & ID Number PETERSON PARK HEALTH CARE CTR # 0024463 Report Period Beginning: 01/01/2007 Ending: 2/31/2007

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 FUTURE ASSOCIATES
 Street Address 7514 N. SKOKIE BLVD
 City / State / Zip Code SKOKIE ,IL.
 Phone Number (847)982-1195
 Fax Number (847)982-0992

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

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6		
1	5	UTILITIES	Management Fees	1,106,010	2	\$ 11,905	\$ 605,008	\$ 6,512	1	
2	6	MAINTENANCE	Management Fees	1,106,010	2	14,860	605,008	8,129	2	
3	17	MANAGEMENT FEES	Direct Allocation			129,000		115,000	3	
4	19	PROFESSIONAL FEES	Management Fees	1,106,010	2	11,896	605,008	6,507	4	
5	20	LICENSE	Management Fees	1,106,010	2	425	605,008	232	5	
6	21	CLERICAL & GENERAL	Management Fees	1,106,010	2	320,169	320,169	605,008	175,138	6
7	21	OFFICE	Management Fees	1,106,010	2	104,188	605,008	56,993	7	
8	21	PAYROLL DIRECT	Direct Allocation			109,960	35,337	35,337	8	
9	22	PAYROLL TAX DIRECT	Direct Allocation			8,766		2,818	9	
10	22	EMPLOYEE BENEFITS	Management Fees	1,106,010	2	98,995	605,008	54,152	10	
11	25	AUTO EXPENSE	Management Fees	1,106,010	2	11,466	605,008	6,272	11	
12	26	INSURANCE	Management Fees	1,106,010	2	6,840	605,008	3,742	12	
13	30	DEPRECIATION	Management Fees	1,106,010	2	23,935	605,008	13,093	13	
14	32	AMORTIZATION	Management Fees	1,106,010	2	19,838	605,008	10,852	14	
15	33	REAL ESTATE TAXES	Management Fees	1,106,010	2	22,873	605,008	12,512	15	
16									16	
17									17	
18									18	
19									19	
20									20	
21									21	
22									22	
23									23	
24									24	
25	TOTALS					\$ 895,116	\$ 355,506	\$ 507,289	25	

Facility Name & ID Number

PETERSON PARK HEALTH CARE CTR

0024463

Report Period Beginning:

01/01/2007

Ending:

12/31/2007

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	Name of Lender	2		3	4	5	6		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	Heartland Bank - P.P. Realty		X	MORTGAGE	\$39,040.46	10/16/04	\$ 6,296,100	\$ 141,283	11/01/29	0.0560	\$ 331,953	1						
2												2						
3												3						
4												4						
5												5						
Working Capital																		
6												6						
7	Healthcap - P.P.Realty		X	INSURANCE POLICIES							4,277	7						
8	RON SHABAT	X		WORKING CAPITAL							5,666	8						
9	TOTAL Facility Related				\$39,040.46		\$ 6,296,100	\$ 141,283			\$ 341,896	9						
B. Non-Facility Related*																		
10	IRS, IDR, ETC		X	LATE FEES								10						
11												11						
12												12						
13												13						
14	TOTAL Non-Facility Related						\$	\$			\$	14						
15	TOTALS (line 9+line14)						\$ 6,296,100	\$ 141,283			\$ 341,896	15						

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ N/A Line #

* 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

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2006 report.		\$	226,000	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.)		\$	218,281	2
3. Under or (over) accrual (line 2 minus line 1).		\$	(7,719)	3
4. Real Estate Tax accrual used for 2007 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	205,769	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.)		\$	15,388	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.		\$	213,438	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2002	232,123	8
	2003	216,952	9
	2004	221,771	10
	2005	224,029	11
	2006	218,281	12

THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED ON ~ 101% OF THE PRIOR YEAR REAL ESTATE TAX BILL

THE PAYMENT ON LINE 2 APPLIES TO THE 2006 TAX BILL.

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

NOTES:

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

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 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 PETERSON PARK HEALTH CARE CTR COUNTY COOK

FACILITY IDPH LICENSE NUMBER 0024463

CONTACT PERSON REGARDING THIS REPORT BOB KAGDA

TELEPHONE (847) 675-3585 FAX #: (847) 675-5777

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>13-02-115-052-0000</u>	<u>NURSING HOME</u>	\$ <u>205,768.66</u>	\$ <u>205,768.66</u>
2. <u>10-28-408-025</u>	<u>Management Office</u>	\$ <u>17,925.39</u>	\$ <u>2,868.00</u>
3. <u>10-28-408-026</u>	<u>Management Office</u>	\$ <u>8,706.55</u>	\$ <u>1,393.00</u>
4. <u>10-28-408-027</u>	<u>Management Office</u>	\$ <u>8,706.55</u>	\$ <u>1,393.00</u>
5. <u>10-28-408-028</u>	<u>Management Office</u>	\$ <u>17,948.55</u>	\$ <u>2,872.00</u>
6. <u>10-28-408-029</u>	<u>Management Office</u>	\$ <u>17,948.55</u>	\$ <u>2,872.00</u>
7. <u>10-28-408-030</u>	<u>Management Office</u>	\$ <u>1,891.95</u>	\$ <u>303.00</u>
8. <u>10-28-408-031</u>	<u>Management Office</u>	\$ <u>1,891.95</u>	\$ <u>303.00</u>
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>280,788.15</u>	\$ <u>217,772.66</u>

B. Real Estate Tax Cost Allocations

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

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

C. Tax Bills

Attach a copy of the original 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.

Facility Name & ID Number PETERSON PARK HEALTH CARE CTR

0024463

Report Period Beginning:

01/01/2007 Ending:

12/31/2007

X. BUILDING AND GENERAL INFORMATION:

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

C. Does the Operating Entity? (a) Own the Facility (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.
 (Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? (a) Own the Equipment (b) Rent equipment from a Related Organization. (c) Rent equipment from Completely Unrelated Organization.
 (Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

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

N/A

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:

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1	<u>FACILITY</u>		<u>1986</u>	<u>\$ 283,071</u>	<u>1</u>
2					<u>2</u>
3	TOTALS			\$ 283,071	3

Facility Name & ID Number **PETERSON PARK HEALTH CARE CTR**# **0024463**

Report Period Beginning:

01/01/2007 Ending: 12/31/2007

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

1	2	3	4	5	6	7	8	9		
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	188	1986		\$ 2,548,850	\$	35	\$ 72,824	\$ 72,824	\$ 1,535,374	4
5	Alloc LCF	1986		128,105		30	4,270	4,270	90,029	5
6	Alloc LCF	1987		3,073	98	31.5	98		2,001	6
7										7
8										8
Improvement Type**										
9	Various		1979	4,800					4,800	9
10	Various		1981	57,728					57,728	10
11	Various		1982	11,967					11,967	11
12	Various		1983	3,440					3,440	12
13	Various		1984	12,700					12,700	13
14	Various		1985	98,707					98,707	14
15	Various		1986	42,087					42,087	15
16	Various		1987	17,729	563	31	572	9	11,874	16
17	Various		1988	35,577	1,129	31	1,147	18	22,174	17
18	Various		1989	14,591	463	31	470	7	8,649	18
19	Various		1990	27,693	879	31	894	15	15,543	19
20	Various		1991	62,352	1,980	20	3,118	1,138	50,698	20
21	Various		1992	10,152	322	20	508	186	8,126	21
22	Various		1993	21,815	247	20	1,092	845	15,947	22
23	Various		1994	264,384	5,873	20	13,226	7,353	175,324	23
24	Various		1995	103,507	2,757	20	5,176	2,419	64,459	24
25	Various		1996	35,086	956	20	1,757	801	20,309	25
26	Various		1997	62,950	1,615	20	3,150	1,535	32,750	26
27	Various		1998	49,698	1,275	20	2,487	1,212	24,163	27
28	Various		1999	87,532	2,489	20	4,383	1,894	38,647	28
29	Various		2000	188,443	4,839	20	9,427	4,588	70,930	29
30	Various		2001	73,918	1,897	20	3,700	1,803	24,682	30
31	Various		2002	350,099	8,977	20	17,508	8,531	96,280	31
32	Heat & A/C Motor		01/02/03	1,274	32	20	64	32	287	32
33	New fan, 26" blade		01/02/03	652	17	20	32	15	146	33
34	New smoke detector assembly		01/26/03	865	22	20	43	21	194	34
35	Bathroom remodeling		01/29/03	4,595	117	20	230	113	1,034	35
36	Roof repairs		02/03/03	715	18	20	36	18	161	36

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

See Page 12A, Line 70 for total

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

Facility Name & ID Number **PETERSON PARK HEALTH CARE CTR**# **0024463**

Report Period Beginning:

01/01/2007 Ending: 12/31/2007

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	Installed CCTV for lobby	02/07/03	\$ 1,447	\$ 37	20	\$ 72	\$ 35	\$ 325	37
38	Three compmnt. sink w/drains	02/07/03	950	24	20	47	23	213	38
39	Install CCTV main dining room	02/07/03	1,237	32	20	62	30	279	39
40	Two pipe freezing unit	02/11/03	946	24	20	48	24	214	40
41	B7G motor assembly	02/17/03	2,360	60	20	118	58	531	41
42	Recirculating pump on storage tank	02/21/03	750	20	20	37	17	168	42
43	Nurses call system	03/01/03	765	19	20	38	19	172	43
44	Install CCTV o/s delivery door	03/28/03	1,286	33	20	64	31	289	44
45	Install CCTV basement	03/28/03	1,382	35	20	69	34	311	45
46	Roof repairs	04/10/03	660	17	20	33	16	149	46
47	Defrost clock walk in freezer	04/16/03	573	15	20	28	13	128	47
48	Leak in baseboard	04/29/03	1,161	29	20	58	29	261	48
49	Cedar fencing	05/08/03	2,800	72	20	140	68	630	49
50	Nurses station 2nd floor	05/16/03	550	14	20	27	13	123	50
51	Stockade fencing	06/04/03	1,880	48	20	94	46	423	51
52	Elevator communication system	06/12/03	887	23	20	44	21	199	52
53	Electrical svce basement, cctv panel	06/12/03	532	13	20	27	14	120	53
54	Electrical svce in kitchen	06/12/03	813	21	20	40	19	182	54
55	Telephone svce, outlets, lines	06/12/03	716	18	20	35	17	160	55
56	Montiring system for CCTV	06/12/03	1,044	27	20	53	26	236	56
57	Elevator repairs	06/30/03	10,591	272	20	529	257	2,382	57
58	Verical sewerage pump	07/11/03	5,813	149	20	290	141	1,307	58
59	Patio door	07/29/03	5,774	148	20	289	141	1,300	59
60	Circuit breakers elect svce	08/25/03	942	24	20	47	23	212	60
61	Nurses call system 2nd floor	08/25/03	817	21	20	41	20	194	61
62	B&G circulating pump	08/25/03	3,845	99	20	192	93	865	62
63	Parking lot repaving	09/12/03	5,100	130	20	255	125	1,148	63
64	Pump motor	09/12/03	829	21	20	41	20	186	64
65	Johnson controls	10/21/03	1,146	29	20	58	29	259	65
66	Walk in cooler leaks & short cycles	10/29/03	941	24	20	47	23	212	66
67	Telephone svce, in basement	11/28/03	800	20	20	40	20	180	67
68	Duct control panel	12/30/03	10,800	277	20	540	263	2,430	68
69	Front door locking system	01/07/04	716	18	20	36	18	126	69
70	TOTAL (lines 4 thru 69)		\$ 4,395,937	\$ 38,378		\$ 149,751	\$ 111,373	\$ 2,557,124	70

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

Facility Name & ID Number PETERSON PARK HEALTH CARE CTR

0024463

Report Period Beginning:

01/01/2007 Ending: 12/31/2007

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		\$ 4,395,937	\$ 38,378		\$ 149,751	\$ 111,373	\$ 2,557,124	1
2	2nd floor nurse call system	01/07/04	685	18	20	35	17	121	2
3	2nd floor electrical problem	01/07/04	683	18	20	34	16	119	3
4	CCTV service	01/07/04	1,151	29	20	58	29	202	4
5	Fire dampers actuators	01/15/04	1,424	36	20	71	35	249	5
6	Telephone system	02/29/04	10,557	270	20	528	258	1,848	6
7	Design service	02/29/04	13,045	335	20	653	318	2,284	7
8	Install latching alarm system	03/15/04	1,137	29	20	57	28	199	8
9	Electrical outlets, wall mounts	03/15/04	688	17	20	34	17	120	9
10	Install wall mount, call button & display	03/15/04	738	19	20	37	18	129	10
11	Digital recorder for CCTV	03/22/04	1,544	40	20	77	37	270	11
12	Floor drains	04/12/04	1,074	28	20	53	25	187	12
13	Tele svce in basement	05/05/04	1,275	33	20	63	30	222	13
14	Remove shower base, reinforce walls	05/23/04	2,200	56	20	110	54	385	14
15	Remove shower base, reinforce walls	05/23/04	2,200	56	20	110	54	385	15
16	Tile work 4 bathrooms	05/28/04	4,525	116	20	227	111	793	16
17	Video monitoring system	06/29/04	1,590	41	20	80	39	279	17
18	Electrical outlets, circuit breakers	06/29/04	942	24	20	47	23	165	18
19	12 A/C units	06/30/04	6,262	160	20	313	153	1,096	19
20	Install 220 volt outlet kitchen	06/30/04	553	14	20	27	13	96	20
21	New toilet	07/28/04	650	17	20	32	15	113	21
22	Elec service kitchen	08/20/04	575	15	20	29	14	101	22
23	Elec service 1st floor	08/31/04	542	14	20	27	13	95	23
24	Review alarm system	09/22/04	893	22	20	45	23	157	24
25	Doors	09/24/04	651	16	20	32	16	113	25
26	Route drain lines, new faucets	09/26/04	1,080	27	20	54	27	189	26
27	Cement sidewalk	09/27/04	1,000	26	20	50	24	175	27
28	Rerun return electric cables	10/22/04	699	18	20	35	17	122	28
29	Repair 4" drain pipe	11/20/04	630	16	20	32	16	111	29
30	Drain Lines, pipe fittings	11/30/04	920	23	20	46	23	161	30
31	Roof repairs	11/30/04	850	21	20	42	21	148	31
32	Drain line outside bldg	12/19/04	2,600	67	20	130	63	455	32
33	Install 220 amp outlet	12/27/04	942	24	20	47	23	165	33
34	TOTAL (lines 1 thru 33)		\$ 4,460,242	\$ 40,023		\$ 152,966	\$ 112,943	\$ 2,568,378	34

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

Facility Name & ID Number **PETERSON PARK HEALTH CARE CTR**# **0024463**

Report Period Beginning:

01/01/2007 Ending: 12/31/2007

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		\$ 4,460,242	\$ 40,023		\$ 152,966	\$ 112,943	\$ 2,568,378	1
2	Public address sound system	12/30/04	1,151	29	20	58	29	202	2
3	Cable to office; install speaker kit	01/07/05	786	20	20	39	19	98	3
4	Rear door alarm	01/07/05	670	18	20	33	15	83	4
5	Ceiling mounted tracks	01/17/05	1,047	27	20	53	26	132	5
6	Pump motor & flame contol	01/27/05	4,362	112	20	218	106	545	6
7	Install pump in pit	02/10/05	2,906	75	20	145	70	363	7
8	Nurses call system	03/01/05	669	17	20	33	16	83	8
9	Electric service in basement	03/01/05	808	21	20	41	20	102	9
10	New awning	03/14/05	2,100	53	20	105	52	263	10
11	Replace copper pipe	03/31/05	720	18	20	36	18	90	11
12	Kitchen ceiling light lines;on off switches	04/14/05	1,042	27	20	52	25	130	12
13	Update north nurse call station	05/02/05	654	17	20	33	16	82	13
14	Electric service 2nd floor north	05/02/05	742	19	20	37	18	93	14
15	Monitoring system to rear pkg lot	06/01/05	1,398	36	20	70	34	175	15
16	Installation of exterior insulation	06/15/05	4,000	102	20	200	98	500	16
17	Electric service 2nd floor end rooms	07/05/05	732	18	20	37	19	92	17
18	New fence	07/14/05	14,000	359	20	700	341	1,432	18
19	Roof caulk,membrane & rubberized coat	08/01/05	1,250	32	20	63	31	157	19
20	6 A/C	08/08/05	2,936	76	20	147	71	367	20
21	Lobby & conference room carpeting	08/08/05	3,301	84	20	165	81	413	21
22	Door monitoring system	09/12/05	4,870	125	20	243	118	608	22
23	Electric service 1st floor south	09/28/05	929	24	20	47	23	117	23
24	Rebuilt new blower assembly	10/21/05	3,243	83	20	162	79	405	24
25	Nurses call system 2 south	10/26/05	676	17	20	34	17	85	25
26	4 new thermocouples	01/01/06	1,063	27	20	53	26	80	26
27	Video monitoring system	01/01/06	874	22	20	44	22	66	27
28	Hot water circ pump	01/01/06	1,460	37	20	73	36	110	28
29	Roof top condenser	01/01/06	537	14	20	27	13	40	29
30	Welded plate for storage tank	01/16/06	1,500	38	20	75	37	113	30
31	60 amp cartridge fuse	02/06/06	656	17	20	33	16	49	31
32	Cooler compressor	02/13/06	1,933	50	20	97	47	145	32
33	New wall panel system for elevator	02/22/06	12,247	314	20	612	298	918	33
34	TOTAL (lines 1 thru 33)		\$ 4,535,504	\$ 41,951		\$ 156,731	\$ 114,780	\$ 2,576,516	34

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

Facility Name & ID Number PETERSON PARK HEALTH CARE CTR

0024463

Report Period Beginning:

01/01/2007 Ending: 12/31/2007

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		\$ 4,535,504	\$ 41,951		\$ 156,731	\$ 114,780	\$ 2,576,516	1
2	Pedestrian door weather stripping	03/17/06	857	22	20	43	21	64	2
3	New door keys	03/30/06	1,953	50	20	98	48	147	3
4	Base for Medroom	05/18/06	1,618	42	20	81	39	121	4
5									5
6	Video monitoring system Adm	05/31/06	988	25	20	49	24	74	6
7	A/C repair bad comp. and motor	06/07/06	826	21	20	41	20	52	7
8	Medrooms base & sink	06/21/06	2,438	63	20	122	59	183	8
9	A/C added bullet valves	06/22/06	883	23	20	44	21	66	9
10	Tuner for phone system	07/12/06	546	14	20	27	13	41	10
11	Install 1st floor circuit breaker	07/21/06	621	16	20	31	15	47	11
12	4 mop sink faucets	07/26/06	1,532	39	20	77	38	115	12
13	Eleectrical mtr for circulating pump	08/31/06	1,620	42	20	81	39	122	13
14	Install feed thru circuit breaker	09/08/06	732	19	20	37	18	55	14
15	20 amp 1 pole feed	09/20/06	746	19	20	37	18	56	15
16	40 bathroom exhaust fans	10/10/06	1,737	45	20	87	42	130	16
17	Elec svce to sunshine room	10/25/06	521	13	20	26	13	39	17
18	New hot water heater	12/27/06	10,000	256	20	500	244	750	18
19	Replace toilets & faucets	12/27/06	620	16	20	31	15	47	19
20	Install hot water htr replace copper line	12/27/06	2,100	54	20	105	51	158	20
21	Concrete dock	06/23/07	3,500	107	15	107		107	21
22	Rehab nursing station	10/22/07	11,394	224	20	285	61	285	22
23	Renovation 1st floor corridor and lobby waiting room	06/26/07	255,996	5,043	20	6,400	1,357	6,400	23
24	Renovation therapy rehab room	12/11/07	12,744	251	20	319	68	319	24
25	Security system	05/30/07	6,100	120	20	152	32	152	25
26	Roof	04/19/07	17,600	347	20	440	93	440	26
27	5 ton multiaqua r-22 packaged electric high eff.	05/15/07	32,940	649	20	824	175	824	27
28	cable wiring	06/01/07	12,500	246	20	312	66	312	28
29	nurse call system	08/28/07	10,612	209	20	265	56	265	29
30	circulation & hot water lines	11/27/07	8,770	173	20	219	46	219	30
31	rear entrance door	11/09/07	3,308	65	20	83	18	83	31
32	elevator rehab 4 new nylon plated guide shoes	12/05/07	3,297	65	20	83	18	83	32
33									33
34	TOTAL (lines 1 thru 33)		\$ 4,944,603	\$ 50,229		\$ 167,737	\$ 117,508	\$ 2,588,272	34

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

Facility Name & ID Number PETERSON PARK HEALTH CARE CTR

0024463

Report Period Beginning:

01/01/2007 Ending: 12/31/2007

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9		
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
1	Totals from Page 12D, Carried Forward		\$ 4,944,603	\$ 50,229		\$ 167,737	\$ 117,508	\$ 2,588,272	1	
2	Alloc from LCF	1987	17,631	560	31.5	560		11,334	2	
3	Alloc from LCF	1988	990	31	31.5	31		607	3	
4	Alloc from LCF	1989	368	12	31.5	12		214	4	
5	Alloc from LCF	1993	10,241	262	39	262		3,771	5	
6	Alloc from LCF	1994	15,616	400	39	400		5,386	6	
7	Alloc from LCF	2001	4,349	111	39	111		723	7	
8	Alloc from LCF-5 Ton Trane A/C	2002	1,066	27	39	27		147	8	
9	Alloc from LCF-Office Remodeling	2003	647	17	39	17		65	9	
10	Alloc from LCF-Electrical	2004	2,242	Columns 5 to 9 included on line12			#VALUE!			10
11	Alloc from LCF-Roof	2004	291	63	39	63		239	11	
12	Alloc from LCF 2006:								12	
13	Various blower mtrs, control board	2006	328	Columns 5 to 9 included on line17			#VALUE!			13
14	Parking lot drainage pump	2006	159	Columns 5 to 9 included on line17			#VALUE!			14
15	Catch basin	2006	499	Columns 5 to 9 included on line17			#VALUE!			15
16	Remove, replace drywalls, studs	2006	489	Columns 5 to 9 included on line17			#VALUE!			16
17	10' water guard, sump pump	2006	384					32	17	
18	Alloc from LCF-carpeting	2007	1,727	30	39	30		30	18	
19	Alloc from LCF-painting	2007	1,242	12	39	23	11	23	19	
20									20	
21	Alloc from Future Associates	1987	55,564	1,764		1,793	29	37,436	21	
22	Alloc from Future Associates	1994	16,251	220	VAR	220		10,629	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)		\$ 5,074,687	\$ 53,738		\$ 171,286	\$ #VALUE!	\$ 2,658,908	34	

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

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	\$ 411,001	\$ 21,085	\$ 41,101	\$ 20,016	10	\$ 276,155	71
72	Current Year Purchases	84,424	16,885	4,221	(12,664)	10	4,221	72
73	Fully Depreciated Assets	831,806					831,806	73
74								74
75	TOTALS	\$ 1,327,231	\$ 37,970	\$ 45,322	\$ 7,352		\$ 1,112,182	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 6,684,989	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 91,708	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 216,608	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 124,900	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 3,771,090	85

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

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

G. Construction-in-Progress

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

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: _____

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

If NO, see instructions. YES NO

	1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:	188		\$ 1,094,760			3
4	Additions						4
5							5
6							6
7	TOTAL	188		\$ 1,094,760			7

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: \$ 19542 Description: **SEE SCHEDULE ATTACHED**

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17		2004 SAAB	\$ 644.00	\$ 2,005	17
18		2006 LEXUS	525.00	6,334	18
19		2007 SAAB	781.00	3,482	19
20					20
21	TOTAL		\$ #####	\$ 11,821	21

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 \$ _____

* 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>
<p>THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES</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.

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	39-3	hrs	\$		\$	\$		\$	1
2	Licensed Speech and Language Development Therapist	39-3	hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs	167,242		33,352			200,594	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescripts				165,131		165,131	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): supplies						24,719		24,719	13
14	TOTAL			\$ 167,242		\$ 33,352	\$ 189,850		\$ 390,444	14

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

Facility Name & ID Number PETERSON PARK HEALTH CARE CTR

0024463

Report Period Beginning: 01/01/2007

Ending:

12/31/2007

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2007

(last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 40,607	\$ 47,118	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (185,000))	1,710,485	1,710,485	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	13,335	177,969	6
7	Other Prepaid Expenses	5,200	421,724	7
8	Accounts Receivable (owners or related parties)	874,814	5,946,877	8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,644,441	\$ 8,304,173	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		102,484	13
14	Buildings, at Historical Cost		2,548,850	14
15	Leasehold Improvements, at Historical Cost		2,122,813	15
16	Equipment, at Historical Cost		1,327,231	16
17	Accumulated Depreciation (book methods)		(4,315,833)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <u>Mortgage Cost Net</u>		136,726	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$	\$ 1,922,271	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,644,441	\$ 10,226,444	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 729,573	\$ 1,108,538	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	865,495	1,006,778	29
30	Accrued Salaries Payable	639,812	639,812	30
31	Accrued Taxes Payable (excluding real estate taxes)	524,344	524,344	31
32	Accrued Real Estate Taxes(Sch.IX-B)		205,769	32
33	Accrued Interest Payable		27,566	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 2,759,224	\$ 3,512,807	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		5,765,726	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$ 5,765,726	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 2,759,224	\$ 9,278,533	46
47	TOTAL EQUITY(page 18, line 24)	\$ (114,783)	\$ 947,911	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,644,441	\$ 10,226,444	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (605,996)	1
2	Restatements (describe):		2
3	ROUNDING	(1)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (605,997)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	491,214	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)	\$ 491,214	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)	\$ (114,783)	24 *

* This must agree with page 17, line 47.

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	\$ 8,698,591	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 8,698,591	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	84,571	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 84,571	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	30	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 30	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	ADJ PRIOR YEAR EXPENSE	169,128	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 169,128	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 8,952,320	30

2

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,430,478	31
32	Health Care	3,485,285	32
33	General Administration	2,088,174	33
	B. Capital Expense		
34	Ownership	1,126,123	34
	C. Ancillary Expense		
35	Special Cost Centers	223,202	35
36	Provider Participation Fee	102,930	36
	D. Other Expenses (specify):		
37	OUT-OF-PERIOD EXPENSES		37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 8,456,192	40
41	Income before Income Taxes (line 30 minus line 40)**	496,128	41
42	Income Taxes	(4,914)	42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 491,214	43

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? NO If not, please attach a reconciliation.

TAX RETURN PREPARED ON CASH BASIS

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

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

Facility Name & ID Number **PETERSON PARK HEALTH CARE CTR**

0024463

Report Period Beginning: **01/01/2007**

Ending:

12/31/2007

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	2,033	2,321	\$ 112,891	\$ 48.64	1
2	Assistant Director of Nursing	2,270	2,536	88,058	34.72	2
3	Registered Nurses	33,583	39,598	1,092,811	27.60	3
4	Licensed Practical Nurses	4,001	4,724	101,862	21.56	4
5	CNAs & Orderlies	87,717	95,725	1,064,388	11.12	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	9,280	9,905	308,127	31.11	8
9	Activity Director	5,225	5,783	87,939	15.21	9
10	Activity Assistants	10,274	11,030	107,175	9.72	10
11	Social Service Workers	12,186	13,662	195,464	14.31	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	23,425	25,884	344,980	13.33	15
16	Dishwashers					16
17	Maintenance Workers	4,106	4,434	50,968	11.49	17
18	Housekeepers	17,696	19,673	181,493	9.23	18
19	Laundry	6,614	7,365	84,180	11.43	19
20	Administrator	6,088	6,238	245,330	39.33	20
21	Assistant Administrator	348	373	9,859	26.43	21
22	Other Administrative					22
23	Office Manager	2,508	2,801	51,764	18.48	23
24	Clerical	7,205	7,906	106,225	13.44	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,877	2,126	35,499	16.70	31
32	Other Health Care(specify)	4,597	5,044	85,830	17.02	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	241,033	267,128	\$ 4,354,843 *	\$ 16.30	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	M	\$ 10,183	1-3	35
36	Medical Director	O	0	9-3	36
37	Medical Records Consultant	N	3,825	10-3	37
38	Nurse Consultant	T	1,400	10-3	38
39	Pharmacist Consultant	H	0	10-3	39
40	Physical Therapy Consultant	L	270	10a-3	40
41	Occupational Therapy Consultant	Y	0	10a-3	41
42	Respiratory Therapy Consultant		0	10a-3	42
43	Speech Therapy Consultant	F	0	10a-3	43
44	Activity Consultant	E	2,574	11-3	44
45	Social Service Consultant	E	4,938	12-3	45
46	Other(specify)	S			46
47	Care Plan Consultant		6,528	10-3	47
48					48
49	TOTAL (lines 35 - 48)		\$ 29,718		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	298	\$ 5,075	10-3	50
51	Licensed Practical Nurses			10-3	51
52	Certified Nurse Assistants/Aides			10-3	52
53	TOTAL (lines 50 - 52)	298	\$ 5,075		53

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

(See instructions.)

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

Facility Name & ID Number PETERSON PARK HEALTH CARE CTR

0024463

Report Period Beginning: 01/01/2007

Ending: 12/31/2007

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? YES
- (2) Are there any dues to nursing home associations included on the cost report? YES
If YES, give association name and amount. IL. COUNCIL LONG TERM CARE \$17815
- (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 YR
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ _____ Line 10-2
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? NO
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? _____ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 102,930
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? NO If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? YES
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? NO For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 38,106 Has any meal income been offset against related costs? N/A Indicate the amount. \$ _____
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? NO
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? 5%
d. Have vehicle usage logs been maintained? NO
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? NO
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? YES
g. **Does the facility transport residents to and from day training? NO**
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? NO
Firm Name: _____ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? _____ If no, please explain. _____
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? YES
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? YES
Attach invoices and a summary of services for all architect and appraisal fees