

Facility Name & ID Number PETERSON PARK HEALTH CARE CENTER

0024463 Report Period Beginning: 01/01/2008 Ending: 12/31/2008

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>34,038</u>	1
2		Skilled Pediatric (SNF/PED)			2
3	<u>95</u>	Intermediate (ICF)	<u>95</u>	<u>34,770</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>68,808</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>3,680</u>	<u>187</u>	<u>7,419</u>	<u>11,286</u>	8
9	SNF/PED					9
10	ICF	<u>47,436</u>	<u>3,540</u>	<u>1,143</u>	<u>52,119</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>51,116</u>	<u>3,727</u>	<u>8,562</u>	<u>63,405</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 92.15%

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 _____ and days of care provided 7,419

Medicare Intermediary ADMINASTAR

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/2008 Fiscal Year: 12/31/2008

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

Facility Name & ID Number **PETERSON PARK HEALTH CARE CENTI** # **0024463** Report Period Beginning: **01/01/2008** Ending: **12/31/2008**

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	361,240	49,373	8,367	418,980		418,980		418,980		1
2	Food Purchase		399,179		399,179	(38,046)	361,133	(2,102)	359,031		2
3	Housekeeping	189,043	38,759		227,802		227,802		227,802		3
4	Laundry	87,998	19,035		107,033		107,033		107,033		4
5	Heat and Other Utilities			242,616	242,616		242,616	6,500	249,116		5
6	Maintenance	64,242	11,791	102,520	178,553		178,553	4,022	182,575		6
7	Other (specify):*			13,815	13,815		13,815		13,815		7
8	TOTAL General Services	702,523	518,137	367,318	1,587,978	(38,046)	1,549,932	8,420	1,558,352		8
	B. Health Care and Programs										
9	Medical Director			15,999	15,999		15,999		15,999		9
10	Nursing and Medical Records	2,696,346	176,812	92,370	2,965,528		2,965,528		2,965,528		10
10a	Therapy	261,664	6,475		268,139		268,139		268,139		10a
11	Activities	182,445	20,706	2,280	205,431		205,431		205,431		11
12	Social Services	175,822		5,688	181,510		181,510		181,510		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	3,316,277	203,993	116,337	3,636,607		3,636,607		3,636,607		16
	C. General Administration										
17	Administrative	312,962		689,937	1,002,899		1,002,899	(593,317)	409,582		17
18	Directors Fees										18
19	Professional Services			154,990	154,990		154,990	19,018	174,008		19
20	Dues, Fees, Subscriptions & Promotions			157,716	157,716		157,716	(142,103)	15,613		20
21	Clerical & General Office Expenses	169,896	32,215	338,011	540,122		540,122	(38,290)	501,832		21
22	Employee Benefits & Payroll Taxes			694,756	694,756	38,046	732,802	47,002	779,804		22
23	Inservice Training & Education										23
24	Travel and Seminar			2,163	2,163		2,163		2,163		24
25	Other Admin. Staff Transportation			1,217	1,217		1,217	21,581	22,798		25
26	Insurance-Prop.Liab.Malpractice			6,158	6,158		6,158	174,911	181,069		26
27	Other (specify):*			299,984	299,984		299,984	(292,094)	7,890		27
28	TOTAL General Administration	482,858	32,215	2,344,932	2,860,005	38,046	2,898,051	(803,292)	2,094,759		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,501,658	754,345	2,828,587	8,084,590		8,084,590	(794,872)	7,289,718		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	8,367
	REPAIRS & MAINTENANCE	0
		0
		8,367
3	HOUSEKEEPING	
		0
		0
		0
4	LAUNDRY	
	EQUIPMENT REPAIRS & MAINTENANCE	0
		0
		0
5	HEAT & OTHER UTILITIES	
	GAS HEAT	130,939
	ELECTRICITY	77,376
	WATER	29,100
	CABLE TV - LOBBY	5,201
		0
		242,616
6	MAINTENANCE	
	GROUND MAINTENANCE	1,165
	PAINTING & DECORATING	0
	BUILDING REPAIRS	6,373
	MAINTENANCE TRAVEL	0
	EQUIPMENT MAINTENANCE & REPAIR	70,593
	ELEVATOR MAINTENANCE & REPAIR	16,682
	OUTSIDE LABOR	0
	EXTERMINATING SERVICE	6,785
	FIRE SERVICE	922
		0
		0
		0
		0
		102,520
7	OTHER	
	SCAVENGER	13,575
	SECURITY SERVICE	240
		0
		0
		13,815
9	MEDICAL DIRECTOR	
	MEDICAL DIRECTOR FEES XVIII B 36-2	15,999
		15,999

LINE	SCHED REF	TOTAL
10	NURSING	
	CONTRACT NURSING XVIII C 53-2	78,758
	LABORATORY & XRAY EXPENSE	13,612
	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	0
	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	0
		0
		0
		92,370
10a	THERAPY	
	PHYSICAL THERAPY SERVICES	
	SPEECH THERAPY SERVICES	0
	OCCUPATIONAL THERAPY SERVICES	0
	REHABILITATION CONSULTANT XVIII B ___-2	0
	PHYSICAL THERAPY CONSULTANT XVIII B 40-2	0
	OCCUPATIONAL THERAPY CONSULTANT XVIII B 41-2	0
	RESPIRATORY THERAPY CONSULTANT XVIII B 42-2	0
	SPEECH THERAPY CONSULTANT XVIII B 43-2	0
		0
11	ACTIVITIES	
	CABLE TV - PATIENT ROOMS	
	ACTIVITY REHAB CONSULTANT XVIII B 44-2	2,280
		0
		2,280
12	SOCIAL SERVICES	
	SOCIAL REHABILITATION SERVICES	
	SOCIAL REHABILITATION CONSULTANT XVIII B 45-2	5,688
	SOCIAL WORKER XVIII B 45-2	0
		0
		5,688
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	689,937
	DIRECTORS FEES	
18	DIRECTORS FEES	0
19	PROFESSIONAL SERVICES	
	DATA PROCESSING XIX C	29,836
	ADMINISTRATIVE CONSULTANTS XIX C	0
	PROFESSIONAL FEES XIX C	125,154
		0
		154,990
20	FEES,SUBSCRIPTIONS,PROMOTIONS	
	ENTERTAINMENT & MARKETING VI 19 XIX F	0
	ADV & PROMO-NON PATIENT RELATED VI 25 XIX F	122,715
	EMPLOYEE WANT ADS XIX F	449
	CONTRIBUTIONS VI 20 XIX F	8,300
	DUES & SUBSCRIPTIONS XIX F	6,048
	LICENSES & PERMITS XIX F	6,225
	PUBLIC RELATIONS-PATIENT RELATED XIX F	0
	ADVERTISING-YELLOW PAGES VI 28 XIX F	0
	TRUST FEES / FRANCHISE TAX / ETC VI 17 XIX F	0
	CONTRIBUTIONS - POLITICAL VI 20 XIX F	12,339
	HEALTH CARE WORKER BACKGROUND CHEC XIX F	730
	PATIENT BACKGROUND CHECKS XIX F	910
		157,716
21	CLERICAL & GENERAL OFFICE EXPENSES	
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)	1,651
	EQUIPMENT REPAIR & MAINTENANCE	0
	OUTSIDE CLERICAL SERVICES	41,261
	PENALTIES / OVERDRAFT CHARGES VI 18	267,093
	HOME OFFICE EXPENSE	0
	THEFT & DAMAGE LOSS	0
	TELEPHONE	28,006
	MESSENGER SERVICE	0
		0
		338,011

LINE	SCHED REF	TOTAL
22	EMPLOYEE BENEFITS & PAYROLL TAXES	
	FICA TAXES XIX D	335,237
	UNEMPLOYMENT COMPENSATION XIX D	34,165
	WORKERS COMPENSATION INSURANC XIX D	94,083
	HOSPITALIZATION INSURANCE XIX D	163,029
	EMPLOYEE BENEFITS - OTHER XIX D	24,128
	EMPLOYEE PHYSICAL EXAMS XIX D	0
	INSURANCE - EXECUTIVE LIFE VI 21/XIX D	2,771
	PENSION/PROFIT SHARING PLANS XIX D	34,299
	CHICAGO HEAD TAX XIX D	7,044
		0
		694,756
23	INSERVICE TRAINING & EDUCATION	
	EDUCATION & SEMINARS	0
		0
24	TRAVEL & SEMINARS	
	EDUCATION & SEMINARS XIX G	2,163
	TRAVEL XIX G	0
		2,163
25	ADMIN. STAFF TRANSPORTATION	
	TRANSPORTATION - STAFF	1,217
		1,217
26	INSURANCE - PROP. LIAB & MALPRACTICE	
	GENERAL INSURANCE	6,158
		6,158
27	OTHER	
	BAD DEBTS VI 24	299,984
		299,984

GRAND TOTAL COLUMN 3 OTHER

2,828,587

**PETERSON PARK HEALTH CARE CENTER
SCHEDULES
12/31/2008**

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

TOTAL FOOD PURCHASE	399,179
LESS SALES TAX	<u>(2,102)</u>
NET FOOD	397,077

TOTAL PATIENT CENSUS	63,405
TIME 3 MEALS PER DAY	<u>3</u>
TOTAL PATIENT MEALS	190,215

ADD # EMPLOYEE MEALS/DAY	55
TIME # DAYS	<u>366</u>
TOTAL EMPLOYEE MEALS	20,130

PATIENT MEALS	190,215
ADD EMPLOYEE MEALS	<u>20,130</u>
TOTAL MEALS/YEAR	210,345

NET FOOD	397,077
DIVIDE TOTAL MEALS/YEAR	<u>210,345</u>

COST PER MEAL	1.89
TIME EMPLOYEE MEALS	<u>20,130</u>
EMPLOYEE MEAL RECLASSIFICATION	38,046

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Facility Name & ID Number

PETERSON PARK HEALTH CARE CENTER

#0024463

Report Period Beginning:

01/01/2008

Ending:

12/31/2008

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost 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	
	D. Ownership											
30	Depreciation							246,079	246,079			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			167,802	167,802		167,802	234,372	402,174			32
33	Real Estate Taxes							173,251	173,251			33
34	Rent-Facility & Grounds			1,066,860	1,066,860		1,066,860	(1,066,860)				34
35	Rent-Equipment & Vehicles			15,331	15,331		15,331		15,331			35
36	Other (specify):*							29,094	29,094			36
37	TOTAL Ownership			1,249,993	1,249,993		1,249,993	(384,064)	865,929			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		280,625	255,884	536,509		536,509		536,509			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			103,212	103,212		103,212		103,212			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		280,625	359,096	639,721		639,721		639,721			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	4,501,658	1,034,970	4,437,676	9,974,304		9,974,304	(1,178,936)	8,795,368			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	106,082	30		9
10	Interest and Other Investment Income	(268)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(2,102)	2		13
14	Non-Care Related Interest	(109,027)	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	(267,093)	21		18
19	Entertainment		20		19
20	Contributions	(20,639)	20		20
21	Owner or Key-Man Insurance	(2,771)	22		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(299,984)	27		24
25	Fund Raising, Advertising and Promotional	(122,715)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising		20		28
29	Other-Attach Schedule	(16,274)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (734,791)		\$	30

BHF USE ONLY							
48		49		50		51	

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)	(444,145)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (444,145)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (1,178,936)		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						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

STATE OF ILLINOIS
 PETERSON PARK HEALTH CARE CENTER

ID# 0024463

Report Period Beginning: 01/01/2008

Ending: 12/31/2008

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	DEFERRED MAINTENANCE	\$ 200	6	1
2	BANK CHARGES	(1,651)	21	2
3	MARKETING SALARY	(14,823)	21	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	(16,274)		49

STATE OF ILLINOIS

Summary A

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

Report Period Beginning:

01/01/2008

Ending:

12/31/2008

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	(2,102)	0	0	0	0	0	0	0	0	0	0	(2,102)	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	6,500	0	0	0	0	0	0	0	0	6,500	5
6	Maintenance	200	0	3,822	0	0	0	0	0	0	0	0	4,022	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(1,902)	0	10,322	0	0	0	0	0	0	0	0	8,420	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	(494,937)	(98,380)	0	0	0	0	0	0	0	(593,317)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	12,250	6,768	0	0	0	0	0	0	0	0	19,018	19
20	Fees, Subscriptions & Promotions	(143,354)	250	1,001	0	0	0	0	0	0	0	0	(142,103)	20
21	Clerical & General Office Expenses	(283,567)	0	245,277	0	0	0	0	0	0	0	0	(38,290)	21
22	Employee Benefits & Payroll Taxes	(2,771)	0	49,773	0	0	0	0	0	0	0	0	47,002	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	21,581	0	0	0	0	0	0	0	0	21,581	25
26	Insurance-Prop.Liab.Malpractice	0	174,470	441	0	0	0	0	0	0	0	0	174,911	26
27	Other (specify):*	(299,984)	0	0	7,890	0	0	0	0	0	0	0	(292,094)	27
28	TOTAL General Administration	(729,676)	186,970	(170,096)	(90,490)	0	(803,292)	28						
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(731,578)	186,970	(159,774)	(90,490)	0	(794,872)	29						

STATE OF ILLINOIS

Summary B

Facility Name & ID Number PETERSON PARK HEALTH CARE CENTER

0024463

Report Period Beginning:

01/01/2008

Ending:

12/31/2008

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	106,082	126,962	13,035	0	0	0	0	0	0	0	0	246,079	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(109,295)	331,835	11,832	0	0	0	0	0	0	0	0	234,372	32
33	Real Estate Taxes	0	161,078	12,173	0	0	0	0	0	0	0	0	173,251	33
34	Rent-Facility & Grounds	0	(1,066,860)	0	0	0	0	0	0	0	0	0	(1,066,860)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	29,094	0	0	0	0	0	0	0	0	0	29,094	36
37	TOTAL Ownership	(3,213)	(417,891)	37,040	0	0	0	0	0	0	0	0	(384,064)	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)	(734,791)	(230,921)	(122,734)	(90,490)	0	(1,178,936)	45						

Facility Name & ID Number PETERSON PARK HEALTH CARE CENTER # 0024463 Report Period Beginning: 01/01/2008 Ending: 12/31/2008

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
	35.4947					
NACHSHON DRAIMAN	43.1702	EMBASSY CARE CENTER	WILMINGTON	SEE SCHEDULE		
RONALD SHABAT	9.4202					
JACK RAJCHENBACH	5.5319					
PPA, LTD	6.383					
MENACHEM SHABAT						

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 Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34 RENT	\$ 1,066,860	PETERSON PARK REALTY		\$	\$ (1,066,860)	1
2	V	19 PROF. FEES. - ACCOUNTING				3,750	3,750	2
3	V	19 PROF. FEES. -H.U.D. AUDIT				8,500	8,500	3
4	V	33 PROF. FEES - R/E REDUCTION				47,500	47,500	4
5	V	20 LICENSES & FEES				250	250	5
6	V	26 INSURANCE - GENERAL				174,470	174,470	6
7	V	30 DEPRECIATION				126,962	126,962	7
8	V	32 INTEREST				331,835	331,835	8
9	V	33 REAL ESTATE TAXES				113,578	113,578	9
10	V	36 INSURANCE H.U.D. (MIP)				29,094	29,094	10
11	V							11
12	V							12
13	V							13
14	Total		\$ 1,066,860			\$ 835,939	\$ * (230,921)	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	\$ 689,937	FUTURE ASSOCIATES		\$	\$ (689,937)
16	V	21 CLERICAL & GENERAL	41,261				(41,261)
17	V	5 UTILITIES				6,500	6,500
18	V	6 MAINTENANCE				3,822	3,822
19	V	17 MANAGEMENT FEES				195,000	195,000
20	V	19 PROFESSIONAL FEES				6,768	6,768
21	V	20 LICENSE				1,001	1,001
22	V	21 PAYROLL				194,553	194,553
23	V	21 PAYROLL - DIRECT				38,048	38,048
24	V	21 OFFICE EXPENSE				53,937	53,937
25	V	22 PAYROLL TAXES DIRECT				3,009	3,009
26	V	22 EMPLOYEE BENEFITS				46,764	46,764
27	V	25 AUTO EXPENSE				21,581	21,581
28	V	26 INSURANCE				441	441
29	V	30 DEPRECIATION				13,035	13,035
30	V	32 AMORTIZATION				11,832	11,832
31	V	33 REAL ESTATE TAXES				12,173	12,173
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 731,198			\$ 608,464	\$ * (122,734)

* 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)	\$ 195,000	FUTURE ASSOCIATES		\$	\$ (195,000)
16	V	17 SALARY		SHABAT & ASSOCIATES		96,620	96,620
17	V	27 PAYROLL TAXES		SHABAT & ASSOCIATES		7,890	7,890
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		\$ 195,000			\$ 104,510	\$ * (90,490)

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

Facility Name & ID Number PETERSON PARK HEALTH CARE CENT # 0024463 Report Period Beginning: 01/01/2008 Ending: 12/31/2008

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	43.17				SALARY	\$ 52,143	17-1	1
2	RONALD SHABAT	Director	Administrative					SALARY	96,620	17-7	2
3											3
4	MENACHEM SHABAT	Director of Operations		6.38				SALARY	158,627	17-1	4
5											5
6	CHAIM RAJCHENBACH	Adiministrator	Administrative					SALARY	75,769	17-1	6
7											7
8	NACHSHON DRAIMAN	Director	Administrative	35.49							8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 383,159		13

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

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

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

0024463

Report Period Beginning:

01/01/2008

Ending: **2/31/2008**

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 PARK HEALTH CARE REALTY
 Street Address 6141 NORTH PULASKI RD
 City / State / Zip Code CHICAGO, IL 60646
 Phone Number (773)478-2000
 Fax Number (847)4788408

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	\$ 3,750	\$	1	\$ 3,750	1
2	19	PROF. FEES. -H.U.D. AUDIT	DIRECT	1	8,500		1	8,500	2
3	33	PROF. FEES - R/E REDUCTION	DIRECT	1	47,500		1	47,500	3
4	20	LICENSES & FEES	DIRECT	1	250		1	250	4
5	26	INSURANCE - GENERAL	DIRECT	1	174,470		1	174,470	5
6	30	DEPRECIATION	DIRECT	1	126,962		1	126,962	6
7	32	INTEREST	DIRECT	1	331,835		1	331,835	7
8	33	REAL ESTATE TAXES	DIRECT	1	113,578		1	113,578	8
9	36	INSURANCE H.U.D. (MIP)	DIRECT	1	29,094		1	29,094	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				\$ 835,939	\$		\$ 835,939	25

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

0024463

Report Period Beginning:

01/01/2008

Ending: **2/31/2008**

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 (847982-1195
 Fax Number (847982-0992

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	5	UTILITIES	Management Fees	2	\$ 11,239	\$	689,937	\$ 6,500	1
2	6	MAINTENANCE	Management Fees	2	6,608		689,937	3,822	2
3	17	MANAGEMENT FEES	Direct Allocation					195,000	3
4	19	PROFESSIONAL FEES	Management Fees	2	11,702		689,937	6,768	4
5	20	LICENSE	Management Fees	2	1,730		689,937	1,001	5
6	21	PAYROLL	Management Fees	2	336,379		689,937	194,553	6
7	21	PAYROLL - DIRECT	Direct Allocation					38,048	7
8	21	OFFICE EXPENSE	Management Fees	2	93,256		689,937	53,937	8
9	22	PAYROLL TAXES DIRECT	Direct Allocation					3,009	9
10	22	EMPLOYEE BENEFITS	Management Fees	2	80,855		689,937	46,764	10
11	25	AUTO EXPENSE	Management Fees	2	37,314		689,937	21,581	11
12	26	INSURANCE	Management Fees	2	763		689,937	441	12
13	30	DEPRECIATION	Management Fees	2	22,537		689,937	13,035	13
14	32	AMORTIZATION	Management Fees	2	20,457		689,937	11,832	14
15	33	REAL ESTATE TAXES	Management Fees	2	21,047		689,937	12,173	15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 643,887	\$		\$ 608,464	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	2	3	4	5	6		7	8	9	10	
					Original	Balance					
Name of Lender	Related** YES NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
A. Directly Facility Related											
Long-Term											
1		x	MORTGAGE	\$39,040.46	10/16/04	\$ 6,296,100	\$ 5,765,727	11/01/29	0.0560	\$ 326,838	1
2											2
3											3
4			FUTURE ASSOC							11,832	4
5			HEALTHCAP INSURANCE POLICIES							3,699	5
Working Capital											
6		X	BANK FINANCIAL WORKING CAPITAL	INT	REVOLV		659,310	REVOLV	PRIME +	57,177	6
7		X	Ron Shabbat - WORKING CAPITAL							1,598	7
8		X	Ron Shabbat - P.P. REALTY WORKING CAPITAL							1,298	8
9			TOTAL Facility Related	\$39,040.46		\$ 6,296,100	\$ 6,425,037			\$ 402,442	9
B. Non-Facility Related*											
10		X	IRS, IDR, ETC LATE FEES							109,027	10
11											11
12											12
13											13
14			TOTAL Non-Facility Related			\$	\$			\$ 109,027	14
15			TOTALS (line 9+line14)			\$ 6,296,100	\$ 6,425,037			\$ 511,469	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 29,094 Line # 36

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

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

B. Real Estate Taxes

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 2007 report.		\$	205,769	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.)		\$	215,745	2
3. Under or (over) accrual (line 2 minus line 1).		\$	9,976	3
4. Real Estate Tax accrual used for 2008 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	203,572	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.)		\$	47,500	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.)		\$	(87,797)	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	173,251	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2003	216,952	8
	2004	221,771	9
	2005	224,029	10
	2006	218,281	11
	2007	215,745	12

FOR BHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2007	\$	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:** 2007 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 2007 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2007.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2007 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 2008 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.

2007 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME PETERSON PARK HEALTH CARE CENTER COUNTY COOK

FACILITY IDPH LICENSE NUMBER 0024463

CONTACT PERSON REGARDING THIS REPORT 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 2007 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 2007.

(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>203,571.92</u>	\$ <u>203,572.00</u>
2. <u>10-28-408-025-0000</u>	<u>MANAGEMENT OFFICE</u>	\$ <u>22,904.56</u>	\$ <u>3,764.00</u>
3. <u>10-28-408-026-0000</u>	<u>MANAGEMENT OFFICE</u>	\$ <u>11,215.44</u>	\$ <u>1,843.00</u>
4. <u>10-28-408-027-0000</u>	<u>MANAGEMENT OFFICE</u>	\$ <u>7,209.35</u>	\$ <u>1,184.00</u>
5. <u>10-28-408-028-0000</u>	<u>MANAGEMENT OFFICE</u>	\$ <u>14,624.75</u>	\$ <u>2,403.00</u>
6. <u>10-28-408-029-0000</u>	<u>MANAGEMENT OFFICE</u>	\$ <u>14,624.75</u>	\$ <u>2,403.00</u>
7. <u>10-28-408-030-0000</u>	<u>MANAGEMENT OFFICE</u>	\$ <u>1,755.46</u>	\$ <u>288.00</u>
8. <u>10-28-408-031-0000</u>	<u>MANAGEMENT OFFICE</u>	\$ <u>1,755.46</u>	\$ <u>288.00</u>
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>277,661.69</u>	\$ <u>215,745.00</u>

B. Real Estate Tax Cost Allocations

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

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

C. Tax Bills

Attach a copy of the original 2007 tax bills which were listed in Section A to this statement. Be sure to use the 2007 tax bill which is normally paid during 2008.

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.

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 CENTER**# **0024463**

Report Period Beginning:

01/01/2008 Ending: 12/31/2008

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	\$ 1,608,198	4
5	ALLO LCF	1986		125,701		30	4,270	4,270	94,299	5
6	ALLO LCF	1987		3,016	96	31.5	96		2,097	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	2,077	31		(2,077)	42,087	15
16	Various		1987	17,729	563	31	572	9	12,446	16
17	Various		1988	35,577	1,129	31	1,147	18	23,321	17
18	Various		1989	14,591	463	31	470	7	9,119	18
19	Various		1990	27,693	879	31	894	15	16,437	19
20	Various		1991	62,352	1,980	20	3,118	1,138	53,816	20
21	Various		1992	10,152	322	20	508	186	8,634	21
22	Various		1993	21,815	247	20	1,092	845	17,039	22
23	Various		1994	264,384	5,873	20	13,226	7,353	188,550	23
24	Various		1995	103,507	2,757	20	5,176	2,419	69,635	24
25	Various		1996	35,086	956	20	1,757	801	22,066	25
26	Various		1997	62,950	1,615	20	3,150	1,535	35,900	26
27	Various		1998	49,698	1,275	20	2,487	1,212	26,650	27
28	Various		1999	87,532	2,489	20	4,383	1,894	43,030	28
29	Various		2000	188,443	4,839	20	9,427	4,588	80,357	29
30	Various		2001	73,918	1,897	20	3,700	1,803	28,382	30
31	Various		2002	350,099	8,977	20	17,508	8,531	113,788	31
32	Heat & A/C Motor		01/02/03	1,274	33	20	64	31	351	32
33	New fan, 26" blade		01/02/03	652	17	20	32	15	178	33
34	New smoke detector assembly		01/26/03	865	22	20	43	21	237	34
35	Bathroom remodeling		01/29/03	4,595	118	20	230	112	1,264	35
36	Roof repairs		02/03/03	715	18	20	36		197	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 CENTER**# **0024463**

Report Period Beginning:

01/01/2008 Ending: 12/31/2008

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	\$ 397	37
38	Three compmnt. sink w/drains	02/07/03	950	24	20	47	23	260	38
39	Install CCTV main dining room	02/07/03	1,237	32	20	62	30	341	39
40	Two pipe freezing unit	02/11/03	946	24	20	48	24	262	40
41	B7G motor assembly	02/17/03	2,360	61	20	118	57	649	41
42	Recirculating pump on storage tank	02/21/03	750	20	20	37	17	205	42
43	Nurses call system	03/01/03	765	20	20	38	18	210	43
44	Install CCTV o/s delivery door	03/28/03	1,286	33	20	64	31	353	44
45	Install CCTV basement	03/28/03	1,382	35	20	69	34	380	45
46	Roof repairs	04/10/03	660	17	20	33	16	182	46
47	Defrost clock walk in freezer	04/16/03	573	15	20	28	13	156	47
48	Leak in baseboard	04/29/03	1,161	29	20	58	29	319	48
49	Cedar fencing	05/08/03	2,800	72	20	140	68	770	49
50	Nurses station 2nd floor	05/16/03	550	14	20	27	13	150	50
51	Stockade fencing	06/04/03	1,880	48	20	94	46	517	51
52	Elevator communication system	06/12/03	887	23	20	44	21	243	52
53	Electrical svce basement, cctv panel	06/12/03	532	13	20	27	14	147	53
54	Electrical svce in kitchen	06/12/03	813	21	20	40	19	222	54
55	Telephone svce, outlets, lines	06/12/03	716	18	20	35	17	195	55
56	Montiring system for CCTV	06/12/03	1,044	27	20	53	26	289	56
57	Elevator repairs	06/30/03	10,591	272	20	529	257	2,911	57
58	Verical sewerage pump	07/11/03	5,813	149	20	290	141	1,597	58
59	Patio door	07/29/03	5,774	148	20	289	141	1,589	59
60	Circuit breakers elect svce	08/25/03	942	24	20	47	23	259	60
61	Nurses call system 2nd floor	08/25/03	817	21	20	41	20	235	61
62	B&G circulating pump	08/25/03	3,845	99	20	192	93	1,057	62
63	Parking lot repaving	09/12/03	5,100	131	20	255	124	1,403	63
64	Pump motor	09/12/03	829	21	20	41	20	227	64
65	Johnson controls	10/21/03	1,146	29	20	58	29	317	65
66	Walk in cooler leaks & short cycles	10/29/03	941	24	20	47	23	259	66
67	Telephone svce, in basement	11/28/03	800	20	20	40	20	220	67
68	Duct control panel	12/30/03	10,800	277	20	540	263	2,970	68
69	Front door locking system	01/07/04	716	18	20	36	18	162	69
70	TOTAL (lines 4 thru 69)		\$ 4,393,476	\$ 40,458		\$ 149,749	\$ 109,273	\$ 2,706,873	70

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

Facility Name & ID Number PETERSON PARK HEALTH CARE CENTER

0024463

Report Period Beginning:

01/01/2008 Ending: 12/31/2008

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	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 4,393,476	\$ 40,458		\$ 149,749	\$ 109,291	\$ 2,706,873	1
2	2nd floor nurse call system	01/07/04	685	18	20	35	17	156	2
3	2nd floor electrical problem	01/07/04	683	18	20	34	16	153	3
4	CCTV service	01/07/04	1,151	30	20	58	28	260	4
5	Fire dampers actuators	01/15/04	1,424	37	20	71	34	320	5
6	Telephone system	02/29/04	10,557	271	20	528	257	2,376	6
7	Design service	02/29/04	13,045	335	20	653	318	2,937	7
8	Install latching alarm system	03/15/04	1,137	29	20	57	28	256	8
9	Electrical outlets, wall mounts	03/15/04	688	18	20	34	16	154	9
10	Install wall mount, call button & display	03/15/04	738	19	20	37	18	166	10
11	Digital recorder for CCTV	03/22/04	1,544	40	20	77	37	347	11
12	Floor drains	04/12/04	1,074	28	20	53	25	240	12
13	Tele svce in basement	05/05/04	1,275	33	20	63	30	285	13
14	Remove shower base, reinforce walls	05/23/04	2,200	56	20	110	54	495	14
15	Remove shower base, reinforce walls	05/23/04	2,200	56	20	110	54	495	15
16	Tile work 4 bathrooms	05/28/04	4,525	116	20	227	111	1,020	16
17	Video monitoring system	06/29/04	1,590	41	20	80	39	359	17
18	Electrical outlets, circuit breakers	06/29/04	942	24	20	47	23	212	18
19	12 A/C units	06/30/04	6,262	161	20	313	152	1,409	19
20	Install 220 volt outlet kitchen	06/30/04	553	14	20	27	13	123	20
21	New toilet	07/28/04	650	17	20	32	15	145	21
22	Elec service kitchen	08/20/04	575	15	20	29	14	130	22
23	Elec service 1st floor	08/31/04	542	14	20	27	13	122	23
24	Review alarm system	09/22/04	893	22	20	45	23	202	24
25	Doors	09/24/04	651	16	20	32	16	145	25
26	Route drain lines, new faucets	09/26/04	1,080	27	20	54	27	243	26
27	Cement sidewalk	09/27/04	1,000	26	20	50	24	225	27
28	Rerun return electric cables	10/22/04	699	18	20	35	17	157	28
29	Repair 4" drain pipe	11/20/04	630	16	20	32	16	143	29
30	Drain Lines, pipe fittings	11/30/04	920	23	20	46	23	207	30
31	Roof repairs	11/30/04	850	21	20	42	21	190	31
32	Drain line outside bldg	12/19/04	2,600	67	20	130	63	585	32
33	Install 220 amp outlet	12/27/04	942	24	20	47	23	212	33
34	TOTAL (lines 1 thru 33)		\$ 4,457,781	\$ 42,108		\$ 152,964	\$ 110,856	\$ 2,721,342	34

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

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

Report Period Beginning:

01/01/2008 Ending: 12/31/2008

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		\$ 4,457,781	\$ 42,108		\$ 152,964	\$ 110,856	\$ 2,721,342	1
2	Public address sound system	12/30/04	1,151	29	20	58	29	260	2
3	Cable to office; install speaker kit	01/07/05	786	20	20	39	19	137	3
4	Rear door alarm	01/07/05	670	18	20	33	15	116	4
5	Ceiling mounted tracks	01/17/05	1,047	27	20	53	26	185	5
6	Pump motor & flame contol	01/27/05	4,362	112	20	218	106	763	6
7	Install pump in pit	02/10/05	2,906	75	20	145	70	508	7
8	Nurses call system	03/01/05	669	17	20	33	16	116	8
9	Electric service in basement	03/01/05	808	21	20	41	20	143	9
10	New awning	03/14/05	2,100	53	20	105	52	368	10
11	Replace copper pipe	03/31/05	720	18	20	36	18	126	11
12	Kitchen ceiling light lines;on off switches	04/14/05	1,042	27	20	52	25	182	12
13	Update north nurse call station	05/02/05	654	17	20	33	16	115	13
14	Electric service 2nd floor north	05/02/05	742	19	20	37	18	130	14
15	Monitoring system to rear pkg lot	06/01/05	1,398	36	20	70	34	245	15
16	Installation of exterior insulation	06/15/05	4,000	102	20	200	98	700	16
17	Electric service 2nd floor end rooms	07/05/05	732	18	20	37	19	129	17
18	New fence	07/14/05	14,000	359	20	700	341	2,132	18
19	Roof caulk,membrane & rubberized coat	08/01/05	1,250	32	20	63	31	220	19
20	6 A/C	08/08/05	2,936	76	20	147	71	514	20
21	Lobby & conference room carpeting	08/08/05	3,301	85	20	165	80	578	21
22	Door monitoring system	09/12/05	4,870	125	20	243	118	851	22
23	Electric service 1st floor south	09/28/05	929	24	20	47	23	164	23
24	Rebuilt new blower assembly	10/21/05	3,243	83	20	162	79	567	24
25	Nurses call system 2 south	10/26/05	676	17	20	34	17	119	25
26	4 new thermocouples	01/01/06	1,063	27	20	53	26	133	26
27	Video monitoring system	01/01/06	874	22	20	44	22	110	27
28	Hot water circ pump	01/01/06	1,460	37	20	73	36	183	28
29	Roof top condenser	01/01/06	537	14	20	27	13	67	29
30	Welded plate for storage tank	01/16/06	1,500	38	20	75	37	188	30
31	60 amp cartridge fuse	02/06/06	656	17	20	33	16	82	31
32	Cooler compressor	02/13/06	1,933	50	20	97	47	242	32
33	New wall panel system for elevator	02/22/06	12,247	314	20	612	298	1,530	33
34	TOTAL (lines 1 thru 33)		\$ 4,533,043	\$ 44,037		\$ 156,729	\$ 112,692	\$ 2,733,245	34

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

Facility Name & ID Number PETERSON PARK HEALTH CARE CENTER

0024463

Report Period Beginning:

01/01/2008 Ending: 12/31/2008

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	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 4,533,043	\$ 44,037		\$ 156,729	\$ 112,692	\$ 2,733,245	1
2	Pedestrian door weather stripping	03/17/06	857	22	20	43	21	107	2
3	New door keys	03/30/06	1,953	50	20	98	48	245	3
4	Base for Medroom	05/18/06	1,618	42	20	81	39	202	4
5									5
6	Video monitoring system Adm	05/31/06	988	25	20	49	24	123	6
7	A/C repair bad comp. and motor	06/07/06	826	21	20	41	20	93	7
8	Medrooms base & sink	06/21/06	2,438	63	20	122	59	305	8
9	A/C added bullet valves	06/22/06	883	23	20	44	21	110	9
10	Tuner for phone system	07/12/06	546	14	20	27	13	68	10
11	Install 1st floor circuit breaker	07/21/06	621	16	20	31	15	78	11
12	4 mop sink faucets	07/26/06	1,532	39	20	77	38	192	12
13	Eleectrical mtr for circulating pump	08/31/06	1,620	42	20	81	39	203	13
14	Install feed thru circuit breaker	09/08/06	732	19	20	37	18	92	14
15	20 amp 1 pole feed	09/20/06	746	19	20	37	18	93	15
16	40 bathroom exhaust fans	10/10/06	1,737	45	20	87	42	217	16
17	Elec svce to sunshine room	10/25/06	521	13	20	26	13	65	17
18	New hot water heater	12/27/06	10,000	256	20	500	244	1,250	18
19	Replace toilets & faucets	12/27/06	620	16	20	31	15	78	19
20	Install hot water htr replace copper line	12/27/06	2,100	54	20	105	51	263	20
21	Concrete dock	06/23/07	3,500	233	15	233		340	21
22	Rehab nursing station	10/22/07	11,394	414	20	570	156	855	22
23	Renovation 1st floor corridor and lobby waiting room	06/26/07	255,996	9,309	20	12,800	3,491	19,200	23
24	Renovation therapy rehab room	12/11/07	12,744	463	20	637	174	956	24
25	Security system	05/30/07	6,100	222	20	305	83	457	25
26	Roof	04/19/07	17,600	640	20	880	240	1,320	26
27	5 ton multiaqua r-22 packaged electric high eff.	05/15/07	32,940	1,198	20	1,647	449	2,471	27
28	cable wiring	06/01/07	12,500	455	20	625	170	937	28
29	nurse call system	08/28/07	10,612	386	20	531	145	796	29
30	circulation & hot water lines	11/27/07	8,770	319	20	439	120	658	30
31	rear entrance door	11/09/07	3,308	120	20	165	45	248	31
32	elevator rehab 4 new nylon plated guide shoes	12/05/07	3,297	120	20	165	45	248	32
33	Landscaping	12/31/2008	16,600	554	15	554	554	554	33
34	TOTAL (lines 1 thru 33)		\$ 4,958,742	\$ 59,249		\$ 177,797	\$ 119,102	\$ 2,766,069	34

**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		\$ 4,958,742	\$ 59,249		\$ 177,797	\$ 118,548	\$ 2,766,069	1
2	12/31/2008	3,500	69	27.5	88	19	88	2
3	12/31/2008	5,500	108	27.5	138	30	138	3
4	12/31/2008	4,000	79	27.5	100	21	100	4
5	12/31/2008	2,860	56	27.5	72	16	72	5
6	12/31/2008	3,850	76	27.5	96	20	96	6
7	12/31/2008	4,497	89	27.5	112	23	112	7
8	12/31/2008	2,800	30	27.5	70	40	70	8
9	12/31/2008	11,990	127	27.5	300	173	300	9
10	12/31/2008	3,900	41	27.5	98	57	98	10
11	12/31/2008	10,460	111	27.5	262	151	262	11
12	12/31/2008	7,500	80	27.5	188	108	188	12
13	12/31/2008	3,951	42	27.5	99	57	99	13
14	12/31/2008	20,641	219	27.5	516	297	516	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		\$ 5,044,191	\$ 60,376		\$ 179,936	\$ 119,560	\$ 2,768,208	34

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

Facility Name & ID Number PETERSON PARK HEALTH CARE CENTER

0024463

Report Period Beginning:

01/01/2008 Ending: 12/31/2008

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9		
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
1	Totals from Page 12E, Carried Forward		\$ 5,044,191	\$ 60,376		\$ 179,936	\$ 119,560	\$ 2,768,208	1	
2	Alloc from LCF	1987	17,300	549	31.5	549		11,883	2	
3	Alloc from LCF	1988	972	31	31.5	31		638	3	
4	Alloc from LCF	1989	361	12	31.5	12		226	4	
5	Alloc from LCF	1993	10,049	257	39	257		4,028	5	
6	Alloc from LCF	1994	15,323	393	39	393		5,779	6	
7	Alloc from LCF	2001	4,267	109	39	109		832	7	
8	Alloc from LCF-5 Ton Trane A/C	2002	1,066	27	39	27		174	8	
9	Alloc from LCF-Office Remodeling	2003	635	16	39	16		81	9	
10	Alloc from LCF-Electrical	2004	2,200	Columns 5 to 9 included on line12						10
11	Alloc from LCF-Roof	2004	285	64	39	64		303	11	
12	Alloc from LCF 2006:								12	
13	Various blower mtrs, control board	2006	322	Columns 5 to 9 included on line17						13
14	Parking lot drainage pump	2006	156	Columns 5 to 9 included on line17						14
15	Catch basin	2006	490	Columns 5 to 9 included on line17						15
16	Remove, replace drywalls, studs	2006	479	Columns 5 to 9 included on line17						16
17	10' water guard, sump pump	2006	377	47		47		79	17	
18	Alloc from LCF-carpeting	2007	1,826	261	39	261		291	18	
19	Alloc from LCF-painting	2007	1,313	188	39	188		211	19	
20									20	
21	Alloc from Future Associates	1987	54,521	1,731		1,759	28	39,195	21	
22	Alloc from Future Associates	1994	15,946	216	VAR	216		10,845	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)		\$ 5,172,079	\$ 64,277		\$ 183,865	\$ 119,588	\$ 2,842,773	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	\$ 495,425	\$ 33,766	\$ 49,543	\$ 15,777		\$ 329,919	71
72	Current Year Purchases	54,859	32,916	2,743	(30,173)		2,743	72
73	Fully Depreciated Assets	831,806					831,806	73
74	allocation from future		3,928	4,818	890			74
75	TOTALS	\$ 1,382,090	\$ 70,610	\$ 57,104	\$ (13,506)		\$ 1,164,468	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				\$	\$	\$	\$		\$	76
77	Allocation from Future			174,898	5,110	5,110				77
78										78
79										79
80	TOTALS			\$ 174,898	\$ 5,110	\$ 5,110	\$		\$	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)	\$ 7,012,138	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 139,997	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 246,079	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 106,082	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 4,007,241	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		\$ 1,066,860			3
4	Additions							4
5								5
6								6
7	TOTAL		188		\$ 1,066,860			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: \$ 6,237 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		2007 SAAB	\$ 744.11	\$ 2,367	17
18		2006 LEXUS	572.00	6,727	18
19					19
20					20
21	TOTAL		#####	\$ 9,094	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. _____/2009 \$ _____

13. _____/2010 \$ _____

14. _____/2011 \$ _____

* 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?</p> <p><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. CLASSROOM PORTION:</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. CLINICAL PORTION:</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	\$		\$ 123,858	\$		\$ 123,858	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			2,293			2,293	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			113,757			113,757	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				280,625		280,625	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): radiology,rentals, therapy					15,976			15,976	13
14	TOTAL			\$		\$ 255,884	\$ 280,625		\$ 536,509	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 CENTER**

0024463

Report Period Beginning: **01/01/2008**

Ending:

12/31/2008

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of **12/31/2008**

(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	\$ 51,391	\$ 58,605	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (100,000))	1,835,881	1,835,881	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	8,468	153,472	6
7	Other Prepaid Expenses	1,688	207,635	7
8	Accounts Receivable (owners or related parties)	658,795	5,648,440	8
9	Other(specify): DUE FROM ECONOCARE	3,500	3,500	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,559,723	\$ 7,907,533	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		4,773,712	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost		1,382,090	16
17	Accumulated Depreciation (book methods)		(4,442,795)	17
18	Deferred Charges		130,487	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):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$	\$ 1,945,978	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,559,723	\$ 9,853,511	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 903,127	\$ 916,877	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	2,448	2,448	28
29	Short-Term Notes Payable	659,311	808,706	29
30	Accrued Salaries Payable	615,153	615,153	30
31	Accrued Taxes Payable (excluding real estate taxes)	167,454	167,454	31
32	Accrued Real Estate Taxes(Sch.IX-B)		203,572	32
33	Accrued Interest Payable	3,082	29,989	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)	\$ 2,350,575	\$ 2,744,199	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		5,616,332	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)	\$	\$ 5,616,332	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 2,350,575	\$ 8,360,531	46
47	TOTAL EQUITY(page 18, line 24)	\$ 209,148	\$ 1,492,980	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,559,723	\$ 9,853,511	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (114,783)	1
2	Restatements (describe):		2
3	ROUNDING	4	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (114,779)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	323,927	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)	\$ 323,927	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)	\$ 209,148	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	\$ 10,048,542	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 10,048,542	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	244,682	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 244,682	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***	268	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 268	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	ADJ. PRIOR YEARS EXPENSE	11,755	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 11,755	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 10,305,247	30

2

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,587,978	31
32	Health Care	3,636,607	32
33	General Administration	2,860,005	33
	B. Capital Expense		
34	Ownership	1,249,993	34
	C. Ancillary Expense		
35	Special Cost Centers	536,509	35
36	Provider Participation Fee	103,212	36
	D. Other Expenses (specify):		
37	OUT-OF-PERIOD EXPENSES		37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 9,974,304	40
41	Income before Income Taxes (line 30 minus line 40)**	330,943	41
42	Income Taxes	(7,016)	42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 323,927	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 CENTER**

0024463

Report Period Beginning: 01/01/2008

Ending:

12/31/2008

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	2,082	2,377	\$ 120,105	\$ 50.53	1
2	Assistant Director of Nursing	1,811	2,316	83,945	36.25	2
3	Registered Nurses	33,367	40,236	1,168,930	29.05	3
4	Licensed Practical Nurses	3,283	4,052	88,906	21.94	4
5	CNAs & Orderlies	95,176	102,781	1,131,609	11.01	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	7,069	7,830	261,664	33.42	8
9	Activity Director	3,910	4,236	68,401	16.15	9
10	Activity Assistants	10,486	11,298	114,044	10.09	10
11	Social Service Workers	11,286	12,769	175,822	13.77	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	23,347	26,125	361,240	13.83	15
16	Dishwashers					16
17	Maintenance Workers	4,332	4,624	64,242	13.89	17
18	Housekeepers	17,768	19,685	189,043	9.60	18
19	Laundry	6,210	6,951	87,998	12.66	19
20	Administrator	7,059	7,083	312,962	44.18	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	10,415	11,292	169,896	15.05	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	1,885	2,094	35,265	16.84	31
32	Other Health C: MDS	2,376	2,628	67,586	25.72	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	241,862	268,377	\$ 4,501,658 *	\$ 16.77	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	\$ 8,367	1-3	35
36	Medical Director	O	15,999	9-3	36
37	Medical Records Consultant	N	0	10-3	37
38	Nurse Consultant	T	0	10-3	38
39	Pharmacist Consultant	H	0	10-3	39
40	Physical Therapy Consultant	L	0	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	2,280	11-3	44
45	Social Service Consultant	E	5,688	12-3	45
46	Other(specify)	S			46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 32,334		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	3,483	\$ 63,710	10-3	50
51	Licensed Practical Nurses	591	15,048	10-3	51
52	Certified Nurse Assistants/Aides			10-3	52
53	TOTAL (lines 50 - 52)	4,074	\$ 78,758		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	FY2005	FY2006	FY2007	FY2008
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 CENTER**# **0024463**Report Period Beginning: **01/01/2008**Ending: **12/31/2008****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. ICLTC \$3127 IL Assoc.Healthcare \$2256
- (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. \$ 1,991 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. \$ 103,212
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. \$ 38,046 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