

		FOR BHF USE					

LL1

**2009**  
**STATE OF ILLINOIS**  
**DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES**  
**FINANCIAL AND STATISTICAL REPORT (COST REPORT)**  
**FOR LONG-TERM CARE FACILITIES**  
**(FISCAL YEAR 2009)**

IMPORTANT NOTICE  
 THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

<p><b>I. IDPH License ID Number:</b> <u>0024463</u></p> <p><b>Facility Name:</b> <u>PETERSON PARK HEALTH CARE CENTER</u></p> <p><b>Address:</b> <u>6141 NORTH PULASKI ROAD</u> <u>CHICAGO</u> <u>60646</u>          Number City Zip Code</p> <p><b>County:</b> <u>COOK</u></p> <p><b>Telephone Number:</b> <u>( 773 ) 478-2000</u> Fax # <u>( 773 ) 478-8408</u></p> <p><b>HFS ID Number:</b> <u>36-2999153</u></p> <p><b>Date of Initial License for Current Owners:</b> <u>01/01/78</u></p> <p><b>Type of Ownership:</b></p> <table border="0"> <tr> <td><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input checked="" type="checkbox"/> PROPRIETARY</td> <td><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input checked="" type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td><b>IRS Exemption Code</b> _____</td> <td><input type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> "Sub-S" Corp.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Limited Liability Co.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other _____</td> <td></td> </tr> </table> <p><b>In the event there are further questions about this report, please contact:</b>  <b>Name:</b> <u>BOB KAGDA</u> <b>Telephone Number:</b> <u>( 847 ) 675-3585</u>  <b>Email Address:</b> _____</p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input checked="" type="checkbox"/> Partnership	<input type="checkbox"/> County	<b>IRS Exemption Code</b> _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input type="checkbox"/> "Sub-S" Corp.			<input type="checkbox"/> Limited Liability Co.			<input type="checkbox"/> Trust			<input type="checkbox"/> Other _____		<p><b>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</b></p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/2009</u> to <u>12/31/2009</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="1"> <tr> <td rowspan="2" style="width: 20%;"><b>Officer or Administrator of Provider</b></td> <td>(Signed) _____</td> </tr> <tr> <td>(Type or Print Name) <u>RONALD SHABAT</u> (Date) _____</td> </tr> <tr> <td></td> <td>(Title) <u>PARTNER</u></td> </tr> <tr> <td rowspan="4"><b>Paid Preparer</b></td> <td>(Signed) <u>(SEE ATTACHED ACCOUNTANTS' REPORT)</u> (Date) _____</td> </tr> <tr> <td>(Print Name and Title) <u>BOB KAGDA</u> <u>VICE PRESIDENT</u></td> </tr> <tr> <td>(Firm Name &amp; Address) <u>KRUPNICK, BOKOR, KAGDA &amp; BROOKS, LTD</u> <u>3750 W DEVON, LINCOLNWOOD, IL 60712-1124</u></td> </tr> <tr> <td>(Telephone) <u>( 847 ) 675-3585</u> Fax # <u>( 847 ) 675-5777</u></td> </tr> </table> <p><b>MAIL TO: BUREAU OF HEALTH FINANCE</b>  <b>ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES</b>  <b>201 S. Grand Avenue East</b>  <b>Springfield, IL 62763-0001</b> Phone # <b>(217) 782-1630</b></p>	<b>Officer or Administrator of Provider</b>	(Signed) _____	(Type or Print Name) <u>RONALD SHABAT</u> (Date) _____		(Title) <u>PARTNER</u>	<b>Paid Preparer</b>	(Signed) <u>(SEE ATTACHED ACCOUNTANTS' REPORT)</u> (Date) _____	(Print Name and Title) <u>BOB KAGDA</u> <u>VICE PRESIDENT</u>	(Firm Name & Address) <u>KRUPNICK, BOKOR, KAGDA &amp; BROOKS, LTD</u> <u>3750 W DEVON, LINCOLNWOOD, IL 60712-1124</u>	(Telephone) <u>( 847 ) 675-3585</u> Fax # <u>( 847 ) 675-5777</u>
<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL																																	
<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State																																	
<input type="checkbox"/> Trust	<input checked="" type="checkbox"/> Partnership	<input type="checkbox"/> County																																	
<b>IRS Exemption Code</b> _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____																																	
	<input type="checkbox"/> "Sub-S" Corp.																																		
	<input type="checkbox"/> Limited Liability Co.																																		
	<input type="checkbox"/> Trust																																		
	<input type="checkbox"/> Other _____																																		
<b>Officer or Administrator of Provider</b>	(Signed) _____																																		
	(Type or Print Name) <u>RONALD SHABAT</u> (Date) _____																																		
	(Title) <u>PARTNER</u>																																		
<b>Paid Preparer</b>	(Signed) <u>(SEE ATTACHED ACCOUNTANTS' REPORT)</u> (Date) _____																																		
	(Print Name and Title) <u>BOB KAGDA</u> <u>VICE PRESIDENT</u>																																		
	(Firm Name & Address) <u>KRUPNICK, BOKOR, KAGDA &amp; BROOKS, LTD</u> <u>3750 W DEVON, LINCOLNWOOD, IL 60712-1124</u>																																		
	(Telephone) <u>( 847 ) 675-3585</u> Fax # <u>( 847 ) 675-5777</u>																																		

Facility Name & ID Number PETERSON PARK HEALTH CARE CENTER

# 0024463 Report Period Beginning: 01/01/2009 Ending: 12/31/2009

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	93	Skilled (SNF)	93	33,945	1
2		Skilled Pediatric (SNF/PED)			2
3	95	Intermediate (ICF)	95	34,675	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	188	TOTALS	188	68,620	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	3,952	849	7,188	11,989	8
9	SNF/PED					9
10	ICF	47,904	2,329	976	51,209	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	51,856	3,178	8,164	63,198	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 92.10%

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 92 and days of care provided 7,188

Medicare Intermediary ADMINISTAR

IV. ACCOUNTING BASIS

ACCRUAL  MODIFIED CASH\*  CASH\*

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

Tax Year: 12/31/2009 Fiscal Year: 12/31/09

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

Facility Name & ID Number **PETERSON PARK HEALTH CARE CENT** # **0024463** Report Period Beginning: **01/01/2009** Ending: **12/31/2009**

**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
	<b>A. General Services</b>										
1	Dietary	362,133	62,041	21,469	445,643		445,643		445,643		1
2	Food Purchase		396,138		396,138	(37,741)	358,397	(2,134)	356,263		2
3	Housekeeping	210,019	64,163		274,182		274,182		274,182		3
4	Laundry	116,395	32,600		148,995		148,995		148,995		4
5	Heat and Other Utilities			167,934	167,934		167,934	3,788	171,722		5
6	Maintenance	61,949	20,284	128,621	210,854		210,854	2,975	213,829		6
7	Other (specify):*			14,448	14,448		14,448		14,448		7
8	<b>TOTAL General Services</b>	750,496	575,226	332,472	1,658,194	(37,741)	1,620,453	4,629	1,625,082		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			33,600	33,600		33,600		33,600		9
10	Nursing and Medical Records	2,724,301	222,892	144,103	3,091,296		3,091,296		3,091,296		10
10a	Therapy	58,032	27	192	58,251		58,251		58,251		10a
11	Activities	197,052	28,146	2,628	227,826		227,826		227,826		11
12	Social Services	168,187		5,897	174,084		174,084		174,084		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	3,147,572	251,065	186,420	3,585,057		3,585,057		3,585,057		16
	<b>C. General Administration</b>										
17	Administrative	155,154		1,090,556	1,245,710		1,245,710	(942,324)	303,386		17
18	Directors Fees										18
19	Professional Services			114,962	114,962		114,962	38,459	153,421		19
20	Dues, Fees, Subscriptions & Promotions			104,324	104,324		104,324	(80,277)	24,047		20
21	Clerical & General Office Expenses	193,700	29,261	163,754	386,715		386,715	19,025	405,740		21
22	Employee Benefits & Payroll Taxes			827,843	827,843	37,741	865,584	6,831	872,415		22
23	Inservice Training & Education										23
24	Travel and Seminar			5,840	5,840		5,840		5,840		24
25	Other Admin. Staff Transportation			1,054	1,054		1,054	2,647	3,701		25
26	Insurance-Prop.Liab.Malpractice			8,937	8,937		8,937	162,420	171,357		26
27	Other (specify):*			142,578	142,578		142,578	(118,044)	24,534		27
28	<b>TOTAL General Administration</b>	348,854	29,261	2,459,848	2,837,963	37,741	2,875,704	(911,263)	1,964,441		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	4,246,922	855,552	2,978,740	8,081,214		8,081,214	(906,634)	7,174,580		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
<b>1</b>	<b>DIETARY</b>	
	DIETITIAN CONSULTANT XVIII B 35-2	10,093
	REPAIRS & MAINTENANCE	11,376
		0
		21,469
<b>3</b>	<b>HOUSEKEEPING</b>	
		0
		0
		0
<b>4</b>	<b>LAUNDRY</b>	
	EQUIPMENT REPAIRS & MAINTENANCE	0
		0
		0
<b>5</b>	<b>HEAT &amp; OTHER UTILITIES</b>	
	GAS HEAT	69,264
	ELECTRICITY	61,888
	WATER	31,503
	CABLE TV - LOBBY	5,279
		0
		167,934
<b>6</b>	<b>MAINTENANCE</b>	
	GROUNDS MAINTENANCE	5,799
	PAINTING & DECORATING	5,960
	BUILDING REPAIRS	13,832
	MAINTENANCE TRAVEL	0
	EQUIPMENT MAINTENANCE & REPAIR	88,721
	ELEVATOR MAINTENANCE & REPAIR	5,101
	OUTSIDE LABOR	0
	EXTERMINATING SERVICE	7,949
	FIRE SERVICE	1,259
		0
		0
		0
		0
		128,621
<b>7</b>	<b>OTHER</b>	
	SCAVENGER	13,948
	SECURITY SERVICE	500
		0
		0
		14,448
<b>9</b>	<b>MEDICAL DIRECTOR</b>	
	MEDICAL DIRECTOR FEES XVIII B 36-2	33,600
		33,600

LINE	SCHED REF	TOTAL
<b>10</b>	<b>NURSING</b>	
	CONTRACT NURSING XVIII C 53-2	134,343
	LABORATORY & XRAY EXPENSE	0
	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	3,760
	UTILIZATION REVIEW FEES XVIII B __-2	0
	PHYSICIANS XVIII B __-2	0
	PSYCHIATRIC XVIII B __-2	0
	RN CONSULTANT XVIII B 38-2	6,000
		0
		0
		144,103
<b>10a</b>	<b>THERAPY</b>	
	PHYSICAL THERAPY SERVICES	
	SPEECH THERAPY SERVICES	0
	OCCUPATIONAL THERAPY SERVICES	0
	REHABILITATION CONSULTANT XVIII B __-2	0
	PHYSICAL THERAPY CONSULTANT XVIII B 40-2	192
	OCCUPATIONAL THERAPY CONSULTA XVIII B 41-2	0
	RESPIRATORY THERAPY CONSULTAN XVIII B 42-2	0
	SPEECH THERAPY CONSULTANT XVIII B 43-2	0
		192
<b>11</b>	<b>ACTIVITIES</b>	
	CABLE TV - PATIENT ROOMS	
	ACTIVITY REHAB CONSULTANT XVIII B 44-2	2,628
		0
		2,628
<b>12</b>	<b>SOCIAL SERVICES</b>	
	SOCIAL REHABILITATION SERVICES	
	SOCIAL REHABILITATION CONSULTAN XVIII B 45-2	5,897
	SOCIAL WORKER XVIII B 45-2	0
		0
		5,897
<b>13</b>	<b>NURSE AIDE TRAINING</b>	
	NURSE AIDE TRAINING COSTS XIII	0
		0



V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE	SCHED REF	TOTAL
14	<b>PROGRAM TRANSPORTATION</b>	
	PATIENT TRANSPORTATION	0
		0
17	<b>ADMINISTRATIVE</b>	
	MANAGEMENT FEES XIX B	1,090,556
	<b>DIRECTORS FEES</b>	
18	DIRECTORS FEES	0
19	<b>PROFESSIONAL SERVICES</b>	
	DATA PROCESSING XIX C	46,282
	ADMINISTRATIVE CONSULTANTS XIX C	0
	PROFESSIONAL FEES XIX C	68,680
		0
		114,962
20	<b>FEES,SUBSCRIPTIONS,PROMOTIONS</b>	
	ENTERTAINMENT & MARKETING VI 19 XIX F	0
	ADV & PROMO-NON PATIENT RELATED VI 25 XIX F	71,682
	EMPLOYEE WANT ADS XIX F	6,960
	CONTRIBUTIONS VI 20 XIX F	2,500
	DUES & SUBSCRIPTIONS XIX F	12,107
	LICENSES & PERMITS XIX F	2,504
	PUBLIC RELATIONS-PATIENT RELATED XIX F	0
	ADVERTISING-YELLOW PAGES VI 28 XIX F	200
	TRUST FEES / FRANCHISE TAX / ETC VI 17 XIX F	0
	CONTRIBUTIONS - POLITICAL VI 20 XIX F	6,411
	HEALTH CARE WORKER BACKGROUND CHEC XIX F	1,210
	PATIENT BACKGROUND CHECKS XIX F	750
		104,324
21	<b>CLERICAL &amp; GENERAL OFFICE EXPENSES</b>	
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)	2,123
	EQUIPMENT REPAIR & MAINTENANCE	0
	OUTSIDE CLERICAL SERVICES	132,113
	PENALTIES / OVERDRAFT CHARGES VI 18	2,520
	HOME OFFICE EXPENSE	0
	THEFT & DAMAGE LOSS	0
	TELEPHONE	26,998
	MESSENGER SERVICE	0
		0
		163,754

LINE	SCHED REF	TOTAL
22	<b>EMPLOYEE BENEFITS &amp; PAYROLL TAXES</b>	
	FICA TAXES XIX D	312,761
	UNEMPLOYMENT COMPENSATION XIX D	30,918
	WORKERS COMPENSATION INSURANC XIX D	143,771
	HOSPITALIZATION INSURANCE XIX D	269,576
	EMPLOYEE BENEFITS - OTHER XIX D	60,512
	EMPLOYEE PHYSICAL EXAMS XIX D	491
	INSURANCE - EXECUTIVE LIFE VI 21/XIX D	2,185
	PENSION/PROFIT SHARING PLANS XIX D	0
	CHICAGO HEAD TAX XIX D	7,629
		0
		827,843
23	<b>INSERVICE TRAINING &amp; EDUCATION</b>	
	EDUCATION & SEMINARS	0
		0
24	<b>TRAVEL &amp; SEMINARS</b>	
	EDUCATION & SEMINARS XIX G	5,840
	TRAVEL XIX G	0
		5,840
25	<b>ADMIN. STAFF TRANSPORTATION</b>	
	TRANSPORTATION - STAFF	1,054
		1,054
26	<b>INSURANCE - PROP. LIAB &amp; MALPRACTICE</b>	
	GENERAL INSURANCE	8,937
		8,937
27	<b>OTHER</b>	
	BAD DEBTS VI 24	142,578
		142,578

GRAND TOTAL COLUMN 3 OTHER **2,978,740**

**PETERSON PARK HEALTH CARE CENTER  
SCHEDULES  
12/31/2009**

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

TOTAL FOOD PURCHASE	396,138
LESS SALES TAX	<u>(2,134)</u>
NET FOOD	394,004

TOTAL PATIENT CENSUS	63,198
TIME 3 MEALS PER DAY	<u>3</u>
TOTAL PATIENT MEALS	189,594

ADD # EMPLOYEE MEALS/DAY	55
TIME # DAYS	<u>365</u>
TOTAL EMPLOYEE MEALS	20,075

PATIENT MEALS	189,594
ADD EMPLOYEE MEALS	<u>20,075</u>
TOTAL MEALS/YEAR	209,669

NET FOOD	394,004
DIVIDE TOTAL MEALS/YEAR	<u>209,669</u>

COST PER MEAL	1.88
TIME EMPLOYEE MEALS	<u>20,075</u>
EMPLOYEE MEAL RECLASSIFICATION	<b>37,741</b>

=====

## 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	
	<b>D. Ownership</b>											
30	Depreciation							259,873	259,873			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			51,784	51,784		51,784	330,101	381,885			32
33	Real Estate Taxes							203,267	203,267			33
34	Rent-Facility & Grounds			1,066,860	1,066,860		1,066,860	(1,066,860)				34
35	Rent-Equipment & Vehicles			12,684	12,684		12,684	268	12,952			35
36	Other (specify):*							28,375	28,375			36
37	<b>TOTAL Ownership</b>			1,131,328	1,131,328		1,131,328	(244,976)	886,352			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		240,114	855,336	1,095,450		1,095,450		1,095,450			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):*							924	924			43
44	<b>TOTAL Special Cost Centers</b>		240,114	958,266	1,198,380		1,198,380	924	1,199,304			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	4,246,922	1,095,666	5,068,334	10,410,922		10,410,922	(1,150,686)	9,260,236			45

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

Facility Name & ID Number PETERSON PARK HEALTH CARE CENTER

# 0024463

Report Period Beginning: 01/01/2009

Ending: 12/31/2009

**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	75,853	30		9
10	Interest and Other Investment Income	(2,766)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(2,134)	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	(2,520)	21		18
19	Entertainment		20		19
20	Contributions	(8,911)	20		20
21	Owner or Key-Man Insurance	(2,185)	22		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(142,578)	27		24
25	Fund Raising, Advertising and Promotional	(71,682)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(200)	20		28
29	Other-Attach Schedule	(885,167)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (1,042,290)		\$	30

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(108,396)		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ (108,396)		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B)</b>	\$ (1,150,686)		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	<b>TOTAL (C): (sum of lines 38-46)</b>			\$		47

BHF USE ONLY						
48		49		50		51
						52

STATE OF ILLINOIS  
**PETERSON PARK HEALTH CARE CENTER**

ID# 0024463  
 Report Period Beginning: 01/01/2009  
 Ending: 12/31/2009

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1		\$		1
2	BANK CHARGES	(2,123)	21	2
3	MARKETING SALRY	(21,520)	21	3
4	CONSULTING	(1,991)	19	4
5	SHABAT & ASSOC	(764,581)	17	5
6	SHABAT & ASSOC	14,859	27	6
7	C. RAJCHENBACH	(78,863)	17	7
8	M. SHABAT	(100,948)	17	8
9	FUTURE ASSOCIATES	70,000	21	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	<b>Total</b>		(885,167)	49

## STATE OF ILLINOIS

Summary A

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

Report Period Beginning:

01/01/2009

Ending:

12/31/2009

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	<b>A. General Services</b>													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(2,134)	0	0	0	0	0	0	0	0	0	0	(2,134)	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	2,564	0	1,224	0	0	0	0	0	0	3,788	5
6	Maintenance	0	0	1,032	1,121	822	0	0	0	0	0	0	2,975	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	<b>TOTAL General Services</b>	<b>(2,134)</b>	<b>0</b>	<b>3,596</b>	<b>1,121</b>	<b>2,046</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>4,629</b>	<b>8</b>
	<b>B. Health Care and Programs</b>													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	<b>TOTAL Health Care and Programs</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative	(944,392)	0	2,068	0	0	0	0	0	0	0	0	(942,324)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(1,991)	29,946	8,608	0	1,896	0	0	0	0	0	0	38,459	19
20	Fees, Subscriptions & Promotions	(80,793)	250	84	0	182	0	0	0	0	0	0	(80,277)	20
21	Clerical & General Office Expenses	43,837	0	(11,894)	899	(13,817)	0	0	0	0	0	0	19,025	21
22	Employee Benefits & Payroll Taxes	(2,185)	0	0	0	9,016	0	0	0	0	0	0	6,831	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	612	0	2,035	0	0	0	0	0	0	2,647	25
26	Insurance-Prop.Liab.Malpractice	0	156,778	5,076	0	566	0	0	0	0	0	0	162,420	26
27	Other (specify):*	(127,719)	0	9,675	0	0	0	0	0	0	0	0	(118,044)	27
28	<b>TOTAL General Administration</b>	<b>(1,113,243)</b>	<b>186,974</b>	<b>14,229</b>	<b>899</b>	<b>(122)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(911,263)</b>	<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	<b>(1,115,377)</b>	<b>186,974</b>	<b>17,825</b>	<b>2,020</b>	<b>1,924</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(906,634)</b>	<b>29</b>

STATE OF ILLINOIS

Summary B

Facility Name & ID Number PETERSON PARK HEALTH CARE CENTER

# 0024463

Report Period Beginning:

01/01/2009 Ending:

12/31/2009

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	75,853	169,214	7,007	5,360	2,439	0	0	0	0	0	0	259,873	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(2,766)	318,388	560	10,210	3,709	0	0	0	0	0	0	330,101	32
33	Real Estate Taxes	0	194,583	5,816	0	2,868	0	0	0	0	0	0	203,267	33
34	Rent-Facility & Grounds	0	(1,066,860)	24,800	(24,800)	0	0	0	0	0	0	0	(1,066,860)	34
35	Rent-Equipment & Vehicles	0	0	19	0	249	0	0	0	0	0	0	268	35
36	Other (specify):*	0	28,375	0	0	0	0	0	0	0	0	0	28,375	36
37	<b>TOTAL Ownership</b>	<b>73,087</b>	<b>(356,300)</b>	<b>38,202</b>	<b>(9,230)</b>	<b>9,265</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(244,976)</b>	<b>37</b>
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	924	0	0	0	0	0	0	0	0	924	43
44	<b>TOTAL Special Cost Centers</b>	<b>0</b>	<b>0</b>	<b>924</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>924</b>	<b>44</b>
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	<b>(1,042,290)</b>	<b>(169,326)</b>	<b>56,951</b>	<b>(7,210)</b>	<b>11,189</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(1,150,686)</b>	<b>45</b>

**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
<b>NACHSHON DRAIMAN</b>	<b>35.4947</b>	<b>EMBASSY CARE CENTER</b>	<b>WILMINGTON</b>			<b>SEE ATTACHED SCHEDULE</b>
<b>RONALD SHABAT</b>	<b>43.1702</b>					
<b>JACK RAJCHENBACH</b>	<b>9.4202</b>					
<b>PPA, LTD</b>	<b>5.5319</b>					
<b>MENACHEM SHABAT</b>	<b>6.383</b>					

**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	<b>34 RENT</b>	\$ <b>1,066,860</b>	<b>PETERSON PARK REALTY</b>		\$	\$ <b>(1,066,860)</b>	1
2	V							2
3	V	<b>19 PROF FEES</b>				<b>29,946</b>	<b>29,946</b>	3
4	V	<b>33 PROF. FEES - R/E REDUCTION</b>				<b>6,530</b>	<b>6,530</b>	4
5	V	<b>20 LICENSES &amp; FEES</b>				<b>250</b>	<b>250</b>	5
6	V	<b>26 INSURANCE - GENERAL</b>				<b>156,778</b>	<b>156,778</b>	6
7	V	<b>30 DEPRECIATION</b>				<b>169,214</b>	<b>169,214</b>	7
8	V	<b>32 INTEREST</b>				<b>318,388</b>	<b>318,388</b>	8
9	V	<b>33 REAL ESTATE TAXES</b>				<b>188,053</b>	<b>188,053</b>	9
10	V	<b>36 INSURANCE H.U.D. (MIP)</b>				<b>28,375</b>	<b>28,375</b>	10
11	V							11
12	V							12
13	V							13
14	<b>Total</b>		\$ <b>1,066,860</b>			\$ <b>897,534</b>	\$ * <b>(169,326)</b>	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	21 OUTSIDE CLERICAL SERVICE	\$ 125,000	LEGACY HEALTHCARE FINANCIAL SERVICES LLC		\$	\$ (125,000)
16	V	5 UTILITIES				2,564	2,564
17	V	6 REPAIRS & MAINTENANCE				1,032	1,032
18	V	19 OTHER PROFESSIONAL FEES				397	397
19	V	19 ACCOUNTING				3,366	3,366
20	V	19 LEGAL				4,330	4,330
21	V	19 DATA PROCESSING				515	515
22	V	20 DUES & SUBSCRIPTION				84	84
23	V	21 OFFICE SUPPLIES				14,153	14,153
24	V	21 WAGES				98,953	98,953
25	V	25 TRAVEL				612	612
26	V	26 INSURANCE EXPENSE				5,076	5,076
27	V	27 EMPLOYEE BENEFITS				9,404	9,404
28	V	30 DEPRECIATION				7,007	7,007
29	V	32 AMORTIZATION				560	560
30	V	33 REAL ESTATE TAXES				5,816	5,816
31	V	34 RENT EXPENSE				24,800	24,800
32	V	35 EQUIPMENT RENTAL				19	19
33	V	43 NON - ALLOWABLE				924	924
34	V	17 SALARY				2,068	2,068
35	V	27 PAYROLL - TAXES				271	271
36	V						
37	V						
38	V						
39	Total		\$ 125,000			\$ 181,951	\$ * 56,951

\* 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	33 REAL ESTATE TAXES	\$ 5,816	LEGACY REAL PROPERTIES LLC		\$	\$ (5,816)
16	V	34 RENT EXPENSE	24,800				(24,800)
17	V	6 REPAIRS & MAINTENANCE				1,121	1,121
18	V	21 OFFICE SUPPLIES				899	899
19	V	30 DEPRECIATION				5,360	5,360
20	V	32 INTEREST EXPENSE				10,210	10,210
21	V	33 REAL ESTATE TAXES				5,816	5,816
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		\$ 30,616			\$ 23,406	\$ * (7,210)

\* 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	21 O/S CLERICAL/ MNGMT FEE	\$ 77,113	FUTURE ASSOCIATIES		\$	\$ (77,113)
16	V	5 UTILITIES				1,224	1,224
17	V	6 MAINTNEANCE				822	822
18	V	19 PROFESSIONAL FEES				1,896	1,896
19	V	20 LICENSE				182	182
20	V	21 CLERICAL PAYROLL				39,429	39,429
21	V	21 CLERICAL PAYROLL DIRECT				15,031	15,031
22	V	21 OFFICE EXPENSE				8,836	8,836
23	V	22 PAYROLL TAXES DIRECT				1,187	1,187
24	V	22 P/R TAXES , EMP. BENEFITS				7,829	7,829
25	V	25 AUTO EXPENSE				2,035	2,035
26	V	26 INSURANCE EXPENSE				566	566
27	V	30 DEPRECIATION				2,439	2,439
28	V	32 INTEREST				3,709	3,709
29	V	33 REAL ESTATE TAXES				2,868	2,868
30	V	35 EQUIPMENT RENTAL				249	249
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 77,113			\$ 88,302	\$ * 11,189

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

Facility Name & ID Number PETERSON PARK HEALTH CARE CEN1 # 0024463 Report Period Beginning: 01/01/2009 Ending: 12/31/2009

## 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		SEE ATTACHED			SALARY	\$ 62,428	17-1	1
2	RONALD SHABAT	DIRECTOR	ADMINISTRATIVE					SALARY	113,475	17-7	2
3	RONALD SHABAT	DIRECTOR	ADMINISTRATIVE					SALARY	2,068	17-7	3
4	MENACHEM SHABAT	DIRECTOR OPERATIONS			SEE ATTACHED			SALARY	6,968	17-1	4
5								Man. Fee	16,552	17-7	5
6	CHAIM RAJCHENBACH	ADMINISTRATOR	ADMINISTRATIVE		SEE ATTACHED			SALARY	4,450	17-1	6
7								Man. Fee	16,137	17-7	7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 222,078		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:

01/01/2009

Ending: 2/31/2009

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 ( 773 ) 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				\$	\$		\$	1
2	PROF. FEES. -	DIRECT	1	1	29,546		1	29,546	2
3	PROF. FEES - R/E REDUCTION	DIRECT	1	1	6,530		1	6,530	3
4	LICENSES & FEES	DIRECT	1	1	250		1	250	4
5	INSURANCE - GENERAL	DIRECT	1	1	156,778		1	156,778	5
6	DEPRECIATION	DIRECT	1	1	169,214		1	169,214	6
7	INTEREST	DIRECT	1	1	318,388		1	318,388	7
8	REAL ESTATE TAXES	DIRECT	1	1	188,053		1	188,053	8
9	INSURANCE H.U.D. (MIP)	DIRECT	1	1	28,375		1	28,375	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				\$ 897,134	\$		\$ 897,134	25

Facility Name & ID Number PETERSON PARK HEALTH CARE CENTER

# 0024463

Report Period Beginning:

01/01/2009

Ending: 2/31/2009

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 LEGACY HEALTHCARE  
 Street Address 7040 RIDGEWAY  
 City / State / Zip Code LINCOLNWOOD ILL 60712  
 Phone Number ( 847 ) 679-9797  
 Fax Number ( 847 ) 679-3676

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	PATIENT DAYS	201,811	5	\$ 8,270	\$ 63,199	\$ 2,564	1
2	6	REPAIRS & MAINTENANCE	PATIENT DAYS	201,811	5	3,328	63,199	1,032	2
3	19	OTHER PROFESSIONAL FEES	PATIENT DAYS	201,811	5	1,281	63,199	397	3
4	19	ACCOUNTING	PATIENT DAYS	201,811	5	10,858	63,199	3,366	4
5	19	LEGAL FEES	PATIENT DAYS	201,811	5	13,965	63,199	4,330	5
6	19	DATA PROCESSING	PATIENT DAYS	201,811	5	1,660	63,199	515	6
7	20	DUES, LICENSES, & FEES	PATIENT DAYS	201,811	5	275	63,199	84	7
8	21	OFFICE SUPPLIES	PATIENT DAYS	201,811	5	45,653	63,199	14,153	8
9	21	WAGES	PATIENT DAYS	201,811	5	319,203	319,203	98,953	9
10	25	TRAVEL	PATIENT DAYS	201,811	5	1,976	63,199	612	10
11	26	INSURANCE	PATIENT DAYS	201,811	5	16,373	63,199	5,076	11
12	27	EMPLOYEE BENEFITS	PATIENT DAYS	201,811	5	30,336	63,199	9,404	12
13	30	DEPRECIATION	PATIENT DAYS	201,811	5	22,605	63,199	7,007	13
14	32	AMORTIZATION	PATIENT DAYS	201,811	5	1,807	63,199	560	14
15	33	REAL ESTATE TAXES	PATIENT DAYS	201,811	5	18,761	63,199	5,816	15
16	34	RENT EXPENSE	PATIENT DAYS	201,811	5	80,000	63,199	24,800	16
17	35	EQUIPMENT RENTAL	PATIENT DAYS	201,811	5	63	63,199	19	17
18	43	NON - ALLOWABLE	PATIENT DAYS	201,811	5	2,978	63,199	924	18
19	17	SALARY	PATIENT DAYS	201,811	5	6,675	6,675	2,068	19
20	27	PAYROLL TAXES	PATIENT DAYS	201,811	5	874	63,199	271	20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 586,941	\$ 325,878	\$ 181,951	25

Facility Name & ID Number PETERSON PARK HEALTH CARE CENTER

# 0024463

Report Period Beginning:

01/01/2009

Ending: 2/31/2009

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 LEGACY REAL PROPERTIES LLC  
 Street Address 7040 RIDGEWAY  
 City / State / Zip Code LINCOLNWOOD ILL 60712  
 Phone Number ( 847 ) 679-9797  
 Fax Number ( 847 ) 679-3676

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	6	REPAIRS & MAINTENANCE	PATIENT DAYS	201,810	5	\$ 3,617	\$ 63,198	\$ 1,121	1
2	21	OFFICE SUPPLIES	PATIENT DAYS	201,810	5	2,900	63,198	899	2
3	30	DEPRECIATION EXPENSE	PATIENT DAYS	201,810	5	17,290	63,198	5,360	3
4	32	INTEREST EXPENSE	PATIENT DAYS	201,810	5	32,936	63,198	10,210	4
5	33	REAL ESTATE TAXES	PATIENT DAYS	201,810	5	18,761	63,198	5,816	5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 75,504	\$	\$ 23,406	25

Facility Name & ID Number PETERSON PARK HEALTH CARE CENTER

# 0024463

Report Period Beginning:

01/01/2009

Ending: 2/31/2009

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	541,740	2	\$ 9,476	\$ 70,000	\$ 1,224	1
2	6	MAINTENNCE	Management Fees	541,740	2	6,361	70,000	822	2
3	19	PROFESSIONAL FEES	Management Fees	541,740	2	14,670	70,000	1,896	3
4	20	LICENSE	Management Fees	541,740	2	1,411	70,000	182	4
5	21	CLERICAL PAYROLL	Management Fees	541,740	2	305,149	70,000	39,429	5
6	21	CLERICAL PAYROLL DIRECT	Direct Allocation					15,031	6
7	21	OFFICE EXPENSE	Management Fees	541,740	2	68,386	70,000	8,836	7
8	22	PAYROLL TAXES DIRECT	Direct Allocation					1,187	8
9	22	P/R TAXES, EMPLOYEE BEN	Management Fees	541,740	2	60,589	70,000	7,829	9
10	25	AUTO EXPENSE	Management Fees	541,740	2	15,753	70,000	2,035	10
11	26	INSURANCE EXPENSE	Management Fees	541,740	2	4,379	70,000	566	11
12	30	DEPRECIATION	Management Fees	541,740	2	18,872	70,000	2,439	12
13	32	INTEREST	Management Fees	541,740	2	28,705	70,000	3,709	13
14	33	REAL ESTATE TAXES	Management Fees	541,740	2	22,195	70,000	2,868	14
15	35	EQUIPMENT RENTAL	Management Fees	541,740	2	1,926	70,000	249	15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 557,872	\$	\$ 88,302	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	Name of Lender	2		3	4	5	6		8	9	10						
			Related**					Purpose of Loan	Monthly Payment Required				Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
			YES	NO										Original	Balance			
		<b>A. Directly Facility Related</b>																
		<b>Long-Term</b>																
1		Heartland Bank - P P Realty		X	MORTGAGE	\$39,040.00	10/16/04	\$ 6,296,100	\$ 5,616,326	11/01/29	0.0560	\$ 318,388	1					
2													2					
3													3					
4		Legacy Real Properties LLC										10,210	4					
5		FUTURE ASSOCIATES										3,709	5					
		<b>Working Capital</b>																
6		BANK FINANCIAL		X	WORKING CAPITAL		REVOLV		1,028,557	REVOLV	PRIME +	50,249	6					
7		IDPA		X								1,297	7					
8		RON SHABAT	X		WORKING CAPITAL							238	8					
9		<b>TOTAL Facility Related</b>				\$39,040.00		\$ 6,296,100	\$ 6,644,883			\$ 384,091	9					
		<b>B. Non-Facility Related*</b>																
10		IRS, IDR, ETC		X	LATE FEES								10					
11													11					
12													12					
13													13					
14		<b>TOTAL Non-Facility Related</b>						\$	\$			\$	14					
15		<b>TOTALS (line 9+line14)</b>						\$ 6,296,100	\$ 6,644,883			\$ 384,091	15					

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 28,375 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.)



**IMPORTANT NOTICE**

**TO:** Long Term Care Facilities with Real Estate Tax Rates    **RE:** 2008 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 2008 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2008.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2008 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 2009 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.

**2008 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 2008 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 2008.

	(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>205,614.45</u>	\$ <u>205,614.45</u>
2.	<u>10-35-104-076-0000</u>	<u>MANAGEMENT OFFICE</u>	\$ _____	\$ <u>5,816.00</u>
3.	<u>10-28-408-025-0000</u>	<u>MANAGEMENT OFFICE</u>	\$ <u>23,535.63</u>	\$ <u>889.00</u>



**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:**

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>FACILITY</u>		<u>1986</u>	<u>\$ 283,071</u>	1
2	<u>REL PARTY- LEGACY</u>		<u>2009</u>	<u>25,361</u>	2
3	<b>TOTALS</b>			<b>\$ 308,432</b>	3

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	\$
5									
6	RELATED PARY- LEGACY REAL PROPERTIES, LLC			308,085	4,669	39	4,669		4,669
7	ALLO LCF	1986		28,082	936	30	936		21,608
8	ALLO LCF	1987		674	21	31.5	21		481
	Improvement Type**								
9	Various		1979	4,800					4,800
10	Various		1981	57,728					57,728
11	Various		1982	11,967					11,967
12	Various		1983	3,440					3,440
13	Various		1984	12,700					12,700
14	Various		1985	98,707					98,707
15	Various		1986	42,087	2,077	31		(2,077)	42,087
16	Various		1987	17,729	563	31	572	9	13,018
17	Various		1988	35,577	1,129	31	1,147	18	24,468
18	Various		1989	14,591	463	31	470	7	9,589
19	Various		1990	27,693	879	31	894	15	17,331
20	Various		1991	62,352	1,980	20	3,118	1,138	56,934
21	Various		1992	10,152	322	20	508	186	9,142
22	Various		1993	21,815	247	20	1,092	845	18,131
23	Various		1994	264,384	5,873	20	13,226	7,353	201,776
24	Various		1995	103,507	2,757	20	5,176	2,419	74,811
25	Various		1996	35,086	956	20	1,757	801	23,823
26	Various		1997	62,950	1,615	20	3,150	1,535	39,050
27	Various		1998	49,698	1,275	20	2,487	1,212	29,137
28	Various		1999	87,532	2,489	20	4,383	1,894	47,413
29	Various		2000	188,443	4,839	20	9,427	4,588	89,784
30	Various		2001	73,918	1,897	20	3,700	1,803	32,082
31	Various		2002	350,099	8,977	20	17,508	8,531	131,296
32	Heat & A/C Motor		01/02/03	1,274	33	20	64	31	415
33	New fan, 26" blade		01/02/03	652	17	20	32	15	210
34	New smoke detector assembly		01/26/03	865	22	20	43	21	280
35	Bathroom remodeling		01/29/03	4,595	118	20	230	112	1,494
36	Roof repairs		02/03/03	715	18	20	36		233

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

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

See Page 12A, Line 70 for total

Facility Name &amp; ID Number PETERSON PARK HEALTH CARE CENTER

# 0024463

Report Period Beginning:

01/01/2009 Ending: 12/31/2009

## 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	\$ 469	37
38	Three compmnt. sink w/drains	02/07/03	950	24	20	47	23	307	38
39	Install CCTV main dining room	02/07/03	1,237	32	20	62	30	403	39
40	Two pipe freezing unit	02/11/03	946	24	20	48	24	310	40
41	B7G motor assembly	02/17/03	2,360	61	20	118	57	767	41
42	Recirculating pump on storage tank	02/21/03	750	20	20	37	17	242	42
43	Nurses call system	03/01/03	765	20	20	38	18	248	43
44	Install CCTV o/s delivery door	03/28/03	1,286	33	20	64	31	417	44
45	Install CCTV basement	03/28/03	1,382	35	20	69	34	449	45
46	Roof repairs	04/10/03	660	17	20	33	16	215	46
47	Defrost clock walk in freezer	04/16/03	573	15	20	28	13	184	47
48	Leak in baseboard	04/29/03	1,161	29	20	58	29	377	48
49	Cedar fencing	05/08/03	2,800	72	20	140	68	910	49
50	Nurses station 2nd floor	05/16/03	550	14	20	27	13	177	50
51	Stockade fencing	06/04/03	1,880	48	20	94	46	611	51
52	Elevator communication system	06/12/03	887	23	20	44	21	287	52
53	Electrical svce basement, cctv panel	06/12/03	532	13	20	27	14	174	53
54	Electrical svce in kitchen	06/12/03	813	21	20	40	19	262	54
55	Telephone svce, outlets, lines	06/12/03	716	18	20	35	17	230	55
56	Montiring system for CCTV	06/12/03	1,044	27	20	53	26	342	56
57	Elevator repairs	06/30/03	10,591	272	20	529	257	3,440	57
58	Verical sewerage pump	07/11/03	5,813	149	20	290	141	1,887	58
59	Patio door	07/29/03	5,774	148	20	289	141	1,878	59
60	Circuit breakers elect svce	08/25/03	942	24	20	47	23	306	60
61	Nurses call system 2nd floor	08/25/03	817	21	20	41	20	276	61
62	B&G circulating pump	08/25/03	3,845	99	20	192	93	1,249	62
63	Parking lot repaving	09/12/03	5,100	131	20	255	124	1,658	63
64	Pump motor	09/12/03	829	21	20	41	20	268	64
65	Johnson controls	10/21/03	1,146	29	20	58	29	375	65
66	Walk in cooler leaks & short cycles	10/29/03	941	24	20	47	23	306	66
67	Telephone svce, in basement	11/28/03	800	20	20	40	20	260	67
68	Duct control panel	12/30/03	10,800	277	20	540	263	3,510	68
69	Front door locking system	01/07/04	716	18	20	36	18	198	69
70	TOTAL (lines 4 thru 69)		\$ 4,601,600	\$ 45,988		\$ 151,009	\$ 105,003	\$ 1,101,596	70

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

Facility Name &amp; ID Number PETERSON PARK HEALTH CARE CENTER

# 0024463

Report Period Beginning:

01/01/2009

Ending:

12/31/2009

## 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	<b>Totals from Page 12A, Carried Forward</b>		\$ 4,601,600	\$ 45,988		\$ 151,009	\$ 105,021	\$ 1,101,596	1
2	2nd floor nurse call system	01/07/04	685	18	20	35	17	191	2
3	2nd floor electrical problem	01/07/04	683	18	20	34	16	187	3
4	CCTV service	01/07/04	1,151	30	20	58	28	318	4
5	Fire dampers actuators	01/15/04	1,424	37	20	71	34	391	5
6	Telephone system	02/29/04	10,557	271	20	528	257	2,904	6
7	Design service	02/29/04	13,045	335	20	653	318	3,590	7
8	Install latching alarm system	03/15/04	1,137	29	20	57	28	313	8
9	Electrical outlets, wall mounts	03/15/04	688	18	20	34	16	188	9
10	Install wall mount, call button & display	03/15/04	738	19	20	37	18	203	10
11	Digital recorder for CCTV	03/22/04	1,544	40	20	77	37	424	11
12	Floor drains	04/12/04	1,074	28	20	53	25	293	12
13	Tele svce in basement	05/05/04	1,275	33	20	63	30	348	13
14	Remove shower base, reinforce walls	05/23/04	2,200	56	20	110	54	605	14
15	Remove shower base, reinforce walls	05/23/04	2,200	56	20	110	54	605	15
16	Tile work 4 bathrooms	05/28/04	4,525	116	20	227	111	1,247	16
17	Video monitoring system	06/29/04	1,590	41	20	80	39	439	17
18	Electrical outlets, circuit breakers	06/29/04	942	24	20	47	23	259	18
19	12 A/C units	06/30/04	6,262	161	20	313	152	1,722	19
20	Install 220 volt outlet kitchen	06/30/04	553	14	20	27	13	150	20
21	New toilet	07/28/04	650	17	20	32	15	177	21
22	Elec service kitchen	08/20/04	575	15	20	29	14	159	22
23	Elec service 1st floor	08/31/04	542	14	20	27	13	149	23
24	Review alarm system	09/22/04	893	22	20	45	23	247	24
25	Doors	09/24/04	651	16	20	32	16	177	25
26	Route drain lines, new faucets	09/26/04	1,080	27	20	54	27	297	26
27	Cement sidewalk	09/27/04	1,000	26	20	50	24	275	27
28	Rerun return electric cables	10/22/04	699	18	20	35	17	192	28
29	Repair 4" drain pipe	11/20/04	630	16	20	32	16	175	29
30	Drain Lines, pipe fittings	11/30/04	920	23	20	46	23	253	30
31	Roof repairs	11/30/04	850	21	20	42	21	232	31
32	Drain line outside bldg	12/19/04	2,600	67	20	130	63	715	32
33	Install 220 amp outlet	12/27/04	942	24	20	47	23	235	33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 4,665,905	\$ 47,638		\$ 154,224	\$ 106,586	\$ 1,119,256	34

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

Facility Name &amp; ID Number PETERSON PARK HEALTH CARE CENTER

# 0024463

Report Period Beginning:

01/01/2009 Ending: 12/31/2009

## 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	<b>Totals from Page 12B, Carried Forward</b>		\$ 4,665,905	\$ 47,638		\$ 154,224	\$ 106,586	\$ 1,119,256	1
2	Public address sound system	12/30/04	1,151	29	20	58	29	318	2
3	Cable to office; install speaker kit	01/07/05	786	20	20	39	19	176	3
4	Rear door alarm	01/07/05	670	18	20	33	15	149	4
5	Ceiling mounted tracks	01/17/05	1,047	27	20	53	26	238	5
6	Pump motor & flame contol	01/27/05	4,362	112	20	218	106	981	6
7	Install pump in pit	02/10/05	2,906	75	20	145	70	653	7
8	Nurses call system	03/01/05	669	17	20	33	16	149	8
9	Electric service in basement	03/01/05	808	21	20	41	20	184	9
10	New awning	03/14/05	2,100	53	20	105	52	473	10
11	Replace copper pipe	03/31/05	720	18	20	36	18	162	11
12	Kitchen ceiling light lines;on off switches	04/14/05	1,042	27	20	52	25	234	12
13	Update north nurse call station	05/02/05	654	17	20	33	16	148	13
14	Electric service 2nd floor north	05/02/05	742	19	20	37	18	167	14
15	Monitoring system to rear pkg lot	06/01/05	1,398	36	20	70	34	315	15
16	Installation of exterior insulation	06/15/05	4,000	102	20	200	98	900	16
17	Electric service 2nd floor end rooms	07/05/05	732	18	20	37	19	166	17
18	New fence	07/14/05	14,000	359	20	700	341	2,832	18
19	Roof caulk,membrane & rubberized coat	08/01/05	1,250	32	20	63	31	283	19
20	6 A/C	08/08/05	2,936	76	20	147	71	661	20
21	Lobby & conference room carpeting	08/08/05	3,301	85	20	165	80	743	21
22	Door monitoring system	09/12/05	4,870	125	20	243	118	1,094	22
23	Electric service 1st floor south	09/28/05	929	24	20	47	23	211	23
24	Rebuilt new blower assembly	10/21/05	3,243	83	20	162	79	729	24
25	Nurses call system 2 south	10/26/05	676	17	20	34	17	153	25
26	4 new thermocouples	01/01/06	1,063	27	20	53	26	186	26
27	Video monitoring system	01/01/06	874	22	20	44	22	154	27
28	Hot water circ pump	01/01/06	1,460	37	20	73	36	256	28
29	Roof top condenser	01/01/06	537	14	20	27	13	94	29
30	Welded plate for storage tank	01/16/06	1,500	38	20	75	37	263	30
31	60 amp cartridge fuse	02/06/06	656	17	20	33	16	115	31
32	Cooler compressor	02/13/06	1,933	50	20	97	47	339	32
33	New wall panel system for elevator	02/22/06	12,247	314	20	612	298	2,142	33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 4,741,167	\$ 49,567		\$ 157,989	\$ 108,422	\$ 1,134,924	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	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	<b>Totals from Page 12C, Carried Forward</b>		\$ 4,741,167	\$ 49,567		\$ 157,989	\$ 108,422	\$ 1,134,924	1
2	Pedestrian door weather stripping	03/17/06	857	22	20	43	21	150	2
3	New door keys	03/30/06	1,953	50	20	98	48	343	3
4	Base for Medroom	05/18/06	1,618	42	20	81	39	283	4
5									5
6	Video monitoring system Adm	05/31/06	988	25	20	49	24	172	6
7	A/C repair bad comp. and motor	06/07/06	826	21	20	41	20	134	7
8	Medrooms base & sink	06/21/06	2,438	63	20	122	59	427	8
9	A/C added bullet valves	06/22/06	883	23	20	44	21	154	9
10	Tuner for phone system	07/12/06	546	14	20	27	13	95	10
11	Install 1st floor circuit breaker	07/21/06	621	16	20	31	15	109	11
12	4 mop sink faucets	07/26/06	1,532	39	20	77	38	269	12
13	Electrical mtr for circulating pump	08/31/06	1,620	42	20	81	39	284	13
14	Install feed thru circuit breaker	09/08/06	732	19	20	37	18	129	14
15	20 amp 1 pole feed	09/20/06	746	19	20	37	18	130	15
16	40 bathroom exhaust fans	10/10/06	1,737	45	20	87	42	304	16
17	Elec svce to sunshine room	10/25/06	521	13	20	26	13	91	17
18	New hot water heater	12/27/06	10,000	256	20	500	244	1,750	18
19	Replace toilets & faucets	12/27/06	620	16	20	31	15	109	19
20	Install hot water htr replace copper line	12/27/06	2,100	54	20	105	51	368	20
21	Concrete dock	06/23/07	3,500	233	15	233		573	21
22	Rehab nursing station	10/22/07	11,394	414	20	570	156	1,425	22
23	Renovation 1st floor corridor and lobby waiting room	06/26/07	255,996	9,309	20	12,800	3,491	32,000	23
24	Renovation therapy rehab room	12/11/07	12,744	463	20	637	174	1,593	24
25	Security system	05/30/07	6,100	222	20	305	83	762	25
26	Roof	04/19/07	17,600	640	20	880	240	2,200	26
27	5 ton multiaqua r-22 packaged electric high eff.	05/15/07	32,940	1,198	20	1,647	449	4,118	27
28	cable wiring	06/01/07	12,500	455	20	625	170	1,562	28
29	nurse call system	08/28/07	10,612	386	20	531	145	1,327	29
30	circulation & hot water lines	11/27/07	8,770	319	20	439	120	1,097	30
31	rear entrance door	11/09/07	3,308	120	20	165	45	413	31
32	elevator rehab 4 new nylon plated guide shoes	12/05/07	3,297	120	20	165	45	413	32
33	Landscaping	12/31/2008	16,600	1,107	15	1,107		1,661	33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 5,166,866	\$ 65,332		\$ 179,610	\$ 114,278	\$ 1,189,369	34

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

Facility Name &amp; ID Number PETERSON PARK HEALTH CARE CENTER

# 0024463

Report Period Beginning:

01/01/2009 Ending: 12/31/2009

## 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	<b>Totals from Page 12D, Carried Forward</b>		\$ 5,166,866	\$ 65,332		\$ 179,610	\$ 114,278	\$ 1,189,369	1
2	Awning	12/31/2008	3,500	127	27.5	127		215	2
3	Elevator Rehab	12/31/2008	5,500	200	27.5	200		338	3
4	Roof	12/31/2008	4,000	145	27.5	145		245	4
5	Copper Piping	12/31/2008	2,860	104	27.5	104		176	5
6	Cable Wiring	12/31/2008	3,850	140	27.5	140		236	6
7	A/C Units	12/31/2008	4,497	163	27.5	163		275	7
8	Gate Valves	12/31/2008	2,800	102	27.5	102		172	8
9	Nurse Call System	12/31/2008	11,990	436	27.5	436		736	9
10	Replace Hot Water and Circulation Lines	12/31/2008	3,900	142	27.5	142		240	10
11	Cable Wiring	12/31/2008	10,460	380	27.5	380		642	11
12	Hot Water Lines	12/31/2008	7,500	273	27.5	273		461	12
13	A/C Units with Sleeves	12/31/2008	3,951	144	27.5	144		243	13
14	Built in Wardrobe Cabinets	12/31/2008	20,641	751	27.5	751		1,267	14
15	PAINTING	2009	39,906	22,946	5	3,991	(18,955)	3,991	15
16	SHADES, CORNICES AND PANELS	2009	51,425	26,998	5	5,143	(21,855)	5,143	16
17	FLOORING AND CARPETING	2009	5,410	2,840	5	541	(2,299)	541	17
18	WALLCOVERINGS, CORNICES AND PANELS	2009	10,770	5,654	5	1,077	(4,577)	1,077	18
19	VINYL FLOORING	2009	5,481	2,878	5	548	(2,330)	548	19
20	SMOKE DETECTORS	2009	7,000	74	27.5	74		74	20
21	GREASE TRAPS	2009	2,790	30	27.5	30		30	21
22	RECONDITION BOILER	2009	6,405	68	27.5	68		68	22
23	HOT WATER LINE	2009	5,180	55	27.5	55		55	23
24	WATER HEATER	2009	3,650	39	27.5	39		39	24
25	NURSE CALL SYSTEM	2009	21,666	230	27.5	230		230	25
26	HOT WATER AND CIRCULATION LINE	2009	5,420	57	27.5	57		57	26
27	HOT WATER AND CIRCULATION PIPES	2009	4,760	50	27.5	50		50	27
28	DRYWALL	2009	2,500	27	27.5	27		27	28
29	COPPER PIPING	2009	5,700	60	27.5	60		60	29
30	bathroom remodeling- lavatorys, light fixtures,wall towels	2009	12,407	132	27.5	132		132	30
31	CHAIR RAIL	2009	4,329	46	27.5	46		46	31
32	DRYWALL AND DRAINS FOR 2 BATHTUBS	2009	5,600	59	27.5	59		59	32
33	PATIO	2009	10,390	260	15	260		260	33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 5,463,104	\$ 130,942		\$ 195,204	\$ 64,262	\$ 1,207,102	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	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation		
1	Totals from Page 12E, Carried Forward		\$ 5,463,104	\$ 130,942		\$ 195,204	\$ 64,262	\$ 1,207,102	1	
2	Alloc from LCF	1987	3,865	123	31.5	123		2,740	2	
3	Alloc from LCF	1988	217	7	31.5	7		147	3	
4	Alloc from LCF	1989	81	3	31.5	3		52	4	
5	Alloc from LCF	1993	2,245	57	39	57		943	5	
6	Alloc from LCF	1994	3,423	88	39	88		1,356	6	
7	Alloc from LCF	2001	953	24	39	24		207	7	
8	Alloc from LCF-5 Ton Trane A/C	2002	234	6	39	6		44	8	
9	Alloc from LCF-Office Remodeling	2003	142	4	39	4		21	9	
10	Alloc from LCF-Electrical	2004	491	Columns 5 to 9 included on line12			#VALUE!			10
11	Alloc from LCF-Roof	2004	64	14	39	14		80	11	
12	Alloc from LCF 2006:								12	
13	Various blower mtrs, control board	2006	72	Columns 5 to 9 included on line17			#VALUE!			13
14	Parking lot drainage pump	2006	35	Columns 5 to 9 included on line17			#VALUE!			14
15	Catch basin	2006	109	Columns 5 to 9 included on line17			#VALUE!			15
16	Remove, replace drywalls, studs	2006	107	Columns 5 to 9 included on line17			#VALUE!			16
17	10' water guard, sump pump	2006	84	10		10		37	17	
18	Alloc from LCF-carpeting	2007	408	58	39	58		124	18	
19	Alloc from LCF-painting	2007	293	42	39	42		89	19	
20									20	
21	Alloc from Future Associates	1987	12,180	393		393		8,992	21	
22	Alloc from Future Associates	1994	3,562	48	VAR	48		2,427	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)		\$ 5,491,669	\$ 131,819		\$ 196,081	\$ #VALUE!	\$ 1,224,361	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	\$ 550,284	\$ 31,242	\$ 54,313	\$ 23,071	10 YRS	\$ 386,975	71
72	Current Year Purchases	23,518	12,656	1,176	(11,480)	10 YRS	1,176	72
73	Fully Depreciated Assets	831,806				10 YRS	831,806	73
74	RELATED PARTY	20,808	8,303	8,303			8,303	74
75	TOTALS	\$ 1,426,416	\$ 52,201	\$ 63,792	\$ 11,591		\$ 1,228,260	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			30,915						77
78										78
79										79
80	TOTALS			\$ 30,915	\$	\$	\$		\$	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)	\$ 7,257,432	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 184,020	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 259,873	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 75,853	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 2,452,621	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	<b>TOTAL</b>		188		\$ 1,066,860			7

10. Effective dates of current rental agreement:

Beginning \_\_\_\_\_

Ending \_\_\_\_\_

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
--	--------------------	-------------

12. \_\_\_\_\_ /2010 \$ \_\_\_\_\_

13. \_\_\_\_\_ /2011 \$ \_\_\_\_\_

14. \_\_\_\_\_ /2012 \$ \_\_\_\_\_

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: \$ \_\_\_\_\_ 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		2006 LEXUS	\$ 572.00	\$ 2,634	17
18		2007 SAAB	744.00	6,697	18
19		2009 LEXUS	660.00	3,353	19
20					20
21	<b>TOTAL</b>		\$ #####	\$ 12,684	21

\* If there is an option to buy the building, please provide complete details on attached schedule.

\*\* This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number PETERSON PARK HEALTH CARE CENTER # 0024463 Report Period Beginning: 01/01/2009 Ending: 12/31/2009  
**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><u>THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES</u></p>	<p>2. <u>CLASSROOM PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
---	---	--

**B. EXPENSES**

ALLOCATION OF COSTS (d)

		Facility			Total
		1	2	3	
		Drop-outs	Completed	Contract	
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	<b>TOTALS</b>	\$	\$	\$	\$
10	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**

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

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

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

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

	Service	1 Schedule V Line & Column Reference	2 Staff		3		4 Outside Practitioner (other than consultant)		5	6	7	8	
			Units of Service	Cost	Units	Cost	Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)				
1	Licensed Occupational Therapist	39-3	hrs	\$		\$	445,975	\$			\$	445,975	1
2	Licensed Speech and Language Development Therapist	39-3	hrs				6,444					6,444	2
3	Licensed Recreational Therapist		hrs										3
4	Licensed Physical Therapist	39-3	hrs				402,917					402,917	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						200,414			200,414	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs										10
11	Academic Education		hrs										11
12	Other (specify):												12
13	Other (specify): <u>radiology,rentals.thera</u>	39-2							39,700			39,700	13
14	<b>TOTAL</b>			\$		\$	855,336	\$	240,114		\$	1,095,450	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: **01/01/2009** Ending: **12/31/2009**  
 XV. BALANCE SHEET - Unrestricted Operating Fund. As of **12/31/2009** (last day of reporting year)

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

		1 Operating	2 After Consolidation*	
<b>A. Current Assets</b>				
1	Cash on Hand and in Banks	\$ 67,433	\$ 82,152	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (160,000) )	2,721,699	2,721,699	3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	46,065	196,150	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	832,742	5,649,440	8
9	Other(specify): <b>ESCROWS</b>		315,162	9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	<b>\$ 3,667,939</b>	<b>\$ 8,964,603</b>	<b>10</b>
<b>B. Long-Term Assets</b>				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		102,484	13
14	Buildings, at Historical Cost		4,984,501	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost		1,405,608	16
17	Accumulated Depreciation (book methods)		(4,612,009)	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):		124,248	23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	<b>\$</b>	<b>\$ 2,004,832</b>	<b>24</b>
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	<b>\$ 3,667,939</b>	<b>\$ 10,969,435</b>	<b>25</b>

		1 Operating	2 After Consolidation*	
<b>C. Current Liabilities</b>				
26	Accounts Payable	\$ 1,790,090	\$ 1,799,840	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable		157,979	29
30	Accrued Salaries Payable	586,578	586,578	30
31	Accrued Taxes Payable (excluding real estate taxes)	113,578	113,578	31
32	Accrued Real Estate Taxes(Sch.IX-B)		205,614	32
33	Accrued Interest Payable		26,210	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
<b>Other Current Liabilities(specify):</b>				
36				36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	<b>\$ 2,490,246</b>	<b>\$ 2,889,799</b>	<b>38</b>
<b>D. Long-Term Liabilities</b>				
39	Long-Term Notes Payable			39
40	Mortgage Payable		5,458,347	40
41	Bonds Payable			41
42	Deferred Compensation			42
<b>Other Long-Term Liabilities(specify):</b>				
43				43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	<b>\$</b>	<b>\$ 5,458,347</b>	<b>45</b>
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	<b>\$ 2,490,246</b>	<b>\$ 8,348,146</b>	<b>46</b>
47	<b>TOTAL EQUITY(page 18, line 24)</b>	<b>\$ 1,177,693</b>	<b>\$ 2,621,289</b>	<b>47</b>
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	<b>\$ 3,667,939</b>	<b>\$ 10,969,435</b>	<b>48</b>

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		1 Total	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>209,148</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>	<b>ROUNDING</b>	<b>(1)</b>	<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>209,147</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>968,546</b>	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	( )	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ <b>968,546</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>1,177,693</b>	<b>24</b> *

\* 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		
<b>A. Inpatient Care</b>				
1	Gross Revenue -- All Levels of Care	\$ 10,800,597	1	
2	Discounts and Allowances for all Levels	( )	2	
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 10,800,597	3	
<b>B. Ancillary Revenue</b>				
4	Day Care		4	
5	Other Care for Outpatients		5	
6	Therapy	544,688	6	
7	Oxygen		7	
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 544,688	8	
<b>C. Other Operating Revenue</b>				
9	Payments for Education		9	
10	Other Government Grants		10	
11	CNA Training Reimbursements		11	
12	Gift and Coffee Shop		12	
13	Barber and Beauty Care		13	
14	Non-Patient Meals		14	
15	Telephone, Television and Radio		15	
16	Rental of Facility Space		16	
17	Sale of Drugs		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	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$	23	
<b>D. Non-Operating Revenue</b>				
24	Contributions		24	
25	Interest and Other Investment Income***	2,766	25	
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 2,766	26	
<b>E. Other Revenue (specify):****</b>				
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27	
28	<b>ADJ PRIOR YEARS EXPENSE</b>	33,420	28	
28a			28a	
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 33,420	29	
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 11,381,471	30	

		2		
Expenses		Amount		
<b>A. Operating Expenses</b>				
31	General Services	1,658,194	31	
32	Health Care	3,585,057	32	
33	General Administration	2,837,963	33	
<b>B. Capital Expense</b>				
34	Ownership	1,131,328	34	
<b>C. Ancillary Expense</b>				
35	Special Cost Centers	1,095,450	35	
36	Provider Participation Fee	102,930	36	
<b>D. Other Expenses (specify):</b>				
37	<b>OUT-OF-PERIOD EXPENSES</b>		37	
38			38	
39			39	
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 10,410,922	40	
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	970,549	41	
42	<b>Income Taxes</b>	(2,003)	42	
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 968,546	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: **01/01/2009**

Ending:

**12/31/2009**

**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	2,015	2,434	\$ 134,627	\$ 55.31	1
2	Assistant Director of Nursing	1,942	2,269	67,397	29.70	2
3	Registered Nurses	33,324	38,098	1,125,127	29.53	3
4	Licensed Practical Nurses	2,882	3,225	75,107	23.29	4
5	CNAs & Orderlies	94,302	103,216	1,141,483	11.06	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,813	2,772	58,032	20.94	8
9	Activity Director	4,672	4,349	69,927	16.08	9
10	Activity Assistants	9,927	12,092	127,125	10.51	10
11	Social Service Workers	14,867	16,639	168,187	10.11	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	22,856	26,060	362,133	13.90	15
16	Dishwashers					16
17	Maintenance Workers	4,547	4,577	61,949	13.53	17
18	Housekeepers	17,203	19,690	210,019	10.67	18
19	Laundry	8,393	9,657	116,395	12.05	19
20	Administrator	2,080	2,080	79,385	38.17	20
21	Assistant Administrator	160	160	1,923	12.02	21
22	Other Administrative	2,175	2,456	73,846	30.07	22
23	Office Manager					23
24	Clerical	11,286	13,269	193,700	14.60	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	1,817	2,329	41,253	17.71	31
32	Other Health Care(specify)	5,172	6,314	139,307	22.06	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	241,433	271,686	\$ 4,246,922 *	\$ 15.63	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	\$ 10,093	1-3	35
36	Medical Director	O	33,600	9-3	36
37	Medical Records Consultant	N	0	10-3	37
38	Nurse Consultant	T	6,000	10-3	38
39	Pharmacist Consultant	H	3,760	10-3	39
40	Physical Therapy Consultant	L	192	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	2,628	11-3	44
45	Social Service Consultant	E	5,897	12-3	45
46	Other(specify)	S			46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 62,170		49

**C. CONTRACT NURSES**

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	16	\$ 432	10-3	50
51	Licensed Practical Nurses	5,885	133,911	10-3	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	5,901	\$ 134,343		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
Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	FY2006	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014
1	<b>PAINT/DECORATING</b>	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2												
3												
4												
5												
6												
7												
8												
9												
10												
11												
12												
13												
14												
15												
16												
17												
18												
19												
20	<b>TOTALS</b>	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

Facility Name &amp; ID Number PETERSON PARK HEALTH CARE CENTER

# 0024463

Report Period Beginning: 01/01/2009 Ending: 12/31/2009

## 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= 9,761 IL ASSOC. HEALTHCARE \$2,256
- (3) Did the nursing home make political contributions or payments to a political action organization? YES If YES, have these costs been properly adjusted out of the cost report? YES
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity? \_\_\_\_\_
- (5) Have you properly capitalized all major repairs and equipment purchases? YES  
What was the average life used for new equipment added during this period? 10 YR
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 0 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 \_\_\_\_\_ 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. \$ 37,741 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: \_\_\_\_\_
- (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.