



Facility Name & ID Number P A Peterson Center for Health

# 0021238 Report Period Beginning: 07/01/09 Ending: 06/30/10

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	129	Skilled (SNF)	129	47,085	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5	29	Sheltered Care (SC)	29	10,585	5
6		ICF/DD 16 or Less			6
7	158	TOTALS	158	57,670	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment				5 Total	
		3 Medicaid Recipient	4 Private Pay	Other	Total		
8	SNF	8,838	25,340	12,907	47,085		8
9	SNF/PED						9
10	ICF						10
11	ICF/DD						11
12	SC		4,311		4,311		12
13	DD 16 OR LESS						13
14	TOTALS	8,838	29,651	12,907	51,396		14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 89.12%

D. How many bed-hold days during this year were paid by the Department? None (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)

Outpatient Therapy

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

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

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

I. On what date did you start providing long term care at this location?  
Date started 1941

J. Was the facility purchased or leased after January 1, 1978?  
YES  Date \_\_\_\_\_ NO

K. Was the facility certified for Medicare during the reporting year?  
YES  NO  If YES, enter number of beds certified 129 and days of care provided 9,000

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRAUAL  MODIFIED CASH\*  CASH\*

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

Tax Year: 06/30/10 Fiscal Year: 06/30/10

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

Facility Name & ID Number P A Peterson Center for Health # 0021238 Report Period Beginning: 07/01/09 Ending: 06/30/10

**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	519,058	34,902	13,406	567,366		567,366		567,366		1
2	Food Purchase		411,309		411,309		411,309	(10,528)	400,781		2
3	Housekeeping	174,366	34,408		208,774		208,774		208,774		3
4	Laundry	15,191	1,148	239,540	255,879		255,879		255,879		4
5	Heat and Other Utilities			265,396	265,396		265,396	2,476	267,872		5
6	Maintenance	131,991	37,191	205,531	374,713		374,713	6,092	380,805		6
7	Other (specify):*							2,423	2,423		7
8	<b>TOTAL General Services</b>	<b>840,606</b>	<b>518,958</b>	<b>723,873</b>	<b>2,083,437</b>		<b>2,083,437</b>	<b>463</b>	<b>2,083,900</b>		<b>8</b>
	<b>B. Health Care and Programs</b>										
9	Medical Director			22,970	22,970		22,970		22,970		9
10	Nursing and Medical Records	3,327,984	73,524	4,030	3,405,538		3,405,538	(5,093)	3,400,445		10
10a	Therapy										10a
11	Activities	139,563	5,707		145,270		145,270		145,270		11
12	Social Services	165,406		1,038	166,444		166,444		166,444		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	<b>3,632,953</b>	<b>79,231</b>	<b>28,038</b>	<b>3,740,222</b>		<b>3,740,222</b>	<b>(5,093)</b>	<b>3,735,129</b>		<b>16</b>
	<b>C. General Administration</b>										
17	Administrative	136,708			136,708		136,708	627,082	763,790		17
18	Directors Fees										18
19	Professional Services			1,163,603	1,163,603		1,163,603	(990,401)	173,202		19
20	Dues, Fees, Subscriptions & Promotions			102,291	102,291		102,291	(58,767)	43,524		20
21	Clerical & General Office Expenses	322,698	30,204	206,185	559,087		559,087	5,182	564,269		21
22	Employee Benefits & Payroll Taxes			1,173,479	1,173,479		1,173,479	123,869	1,297,348		22
23	Inservice Training & Education										23
24	Travel and Seminar			29,008	29,008		29,008	9,814	38,822		24
25	Other Admin. Staff Transportation			7,953	7,953		7,953	9,467	17,420		25
26	Insurance-Prop.Liab.Malpractice			216,010	216,010		216,010	19,622	235,632		26
27	Other (specify):*							42	42		27
28	<b>TOTAL General Administration</b>	<b>459,406</b>	<b>30,204</b>	<b>2,898,529</b>	<b>3,388,139</b>		<b>3,388,139</b>	<b>(254,090)</b>	<b>3,134,049</b>		<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	<b>4,932,965</b>	<b>628,393</b>	<b>3,650,440</b>	<b>9,211,798</b>		<b>9,211,798</b>	<b>(258,720)</b>	<b>8,953,078</b>		<b>29</b>

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY	
		Salary/Wage	Supplies	Other	Total					9	10
	D. Ownership	1	2	3	4	5	6	7	8		
30	Depreciation			548,039	548,039		548,039	136,205	684,244		30
31	Amortization of Pre-Op. & Org.										31
32	Interest			227,928	227,928		227,928	26,840	254,768		32
33	Real Estate Taxes			178,340	178,340		178,340	18	178,358		33
34	Rent-Facility & Grounds							50,279	50,279		34
35	Rent-Equipment & Vehicles			17,053	17,053		17,053	2,054	19,107		35
36	Other (specify):*			5,637	5,637		5,637		5,637		36
37	<b>TOTAL Ownership</b>			976,997	976,997		976,997	215,396	1,192,393		37
	<b>Ancillary Expense</b>										
	<b>E. Special Cost Centers</b>										
38	Medically Necessary Transportation										38
39	Ancillary Service Centers		582,558	1,745,501	2,328,059		2,328,059		2,328,059		39
40	Barber and Beauty Shops										40
41	Coffee and Gift Shops										41
42	Provider Participation Fee			70,628	70,628		70,628		70,628		42
43	Other (specify):*	44,674			44,674		44,674	(44,674)			43
44	<b>TOTAL Special Cost Centers</b>	44,674	582,558	1,816,129	2,443,361		2,443,361	(44,674)	2,398,687		44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	4,977,639	1,210,951	6,443,566	12,632,156		12,632,156	(87,998)	12,544,158		45

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

SEE ACCOUNTANTS' COMPILATION REPORT

**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	(10,528)	02		4
5	Telephone, TV & Radio in Resident Rooms	(38,229)	21		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	77,801	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax		02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(70,783)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(69,773)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (111,512)		\$	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)	23,514		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ 23,514		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ (87,998)		37

\*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

**C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)**

		1	2	3	4	
		Yes	No	Amount	Reference	
38	Medically Necessary Transport.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44						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

SEE ACCOUNTANTS' COMPILATION REPORT

**P A Peterson Center for Health**

**ID# 0021238**

**Report Period Beginning: 07/01/09**

**Ending: 06/30/10**

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Marketing Professions	\$ (44,674)	43	1
2	Refund for Discounts on Supplies	(5,093)	10	2
3	Other Misc. Income	(1,246)	21	3
4	Collection Fees	(1,559)	21	4
5	Late Fees	(529)	21	5
6	Additional R&M	8,348	06	6
7	Capitalized R&M	(25,020)	06	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	<b>Total</b>	(69,773)		49

P A Peterson Center for Health

ID# 0021238

Report Period Beginning: 07/01/09

Ending: 06/30/10

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
50		\$	1
51			2
52			3
53			4
54			5
55			6
56			7
57			8
58			9
59			10
60			11
61			12
62			13
63			14
64			15
65			16
66			17
67			18
68			19
69			20
70			21
71			22
72			23
73			24
74			25
75			26
76			27
77			28
78			29
79			30
80			31
81			32
82			33
83			34
84			35
85			36
86			37
87			38
88			39
89			40
90			41
91			42
92			43
93			44
94			45
95			46
96			47
97			48
98			49

## STATE OF ILLINOIS

Summary A

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

Report Period Beginning:

07/01/09

Ending:

06/30/10

## 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													1
2	Food Purchase	(10,528)											(10,528)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities			2,476									2,476	5
6	Maintenance	(16,672)		21,428	1,336								6,092	6
7	Other (specify):*			2,420	3								2,423	7
8	<b>TOTAL General Services</b>	<b>(27,200)</b>		<b>26,324</b>	<b>1,339</b>								<b>463</b>	<b>8</b>
	<b>B. Health Care and Programs</b>													
9	Medical Director													9
10	Nursing and Medical Records	(5,093)											(5,093)	10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*													15
16	<b>TOTAL Health Care and Programs</b>	<b>(5,093)</b>											<b>(5,093)</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative			394,105	102,953	130,024							627,082	17
18	Directors Fees													18
19	Professional Services			(670,636)	(158,451)	(161,314)							(990,401)	19
20	Fees, Subscriptions & Promotions	(70,783)		2,787	7,563	1,666							(58,767)	20
21	Clerical & General Office Expenses	(41,563)		37,813	3,851	5,081							5,182	21
22	Employee Benefits & Payroll Taxes			72,904	23,710	27,255							123,869	22
23	Inservice Training & Education													23
24	Travel and Seminar			3,233	4,225	2,356							9,814	24
25	Other Admin. Staff Transportation			6,546	905	2,016							9,467	25
26	Insurance-Prop.Liab.Malpractice			18,935	307	380							19,622	26
27	Other (specify):*			(18)		60							42	27
28	<b>TOTAL General Administration</b>	<b>(112,346)</b>		<b>(134,331)</b>	<b>(14,937)</b>	<b>7,524</b>							<b>(254,090)</b>	<b>28</b>
29	<b>TOTAL Operating Expense</b> <b>(sum of lines 8,16 &amp; 28)</b>	<b>(144,639)</b>		<b>(108,007)</b>	<b>(13,598)</b>	<b>7,524</b>							<b>(258,720)</b>	<b>29</b>

## STATE OF ILLINOIS

Summary B

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

Report Period Beginning:

07/01/09

Ending:

06/30/10

## 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	77,801		46,688	9,954	1,762							136,205	30
31	Amortization of Pre-Op. & Org.													31
32	Interest			10,811	1,003	15,026							26,840	32
33	Real Estate Taxes			18									18	33
34	Rent-Facility & Grounds			47,962	2,317								50,279	34
35	Rent-Equipment & Vehicles			1,409	57	588							2,054	35
36	Other (specify):*													36
37	<b>TOTAL Ownership</b>	<b>77,801</b>		<b>106,888</b>	<b>13,331</b>	<b>17,376</b>							<b>215,396</b>	<b>37</b>
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers													39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(44,674)											(44,674)	43
44	<b>TOTAL Special Cost Centers</b>	<b>(44,674)</b>											<b>(44,674)</b>	<b>44</b>
	<b>GRAND TOTAL COST</b>													
45	(sum of lines 29, 37 & 44)	(111,512)		(1,119)	(267)	24,900							(87,998)	45

**VII. RELATED PARTIES**

**A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.**

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
LSSI	100%	St. Mathews	Park Ridge	Vesper Mgmt. Corp	Des Plaines	Mgmt. Co.
				LSSI	Des Plaines	Corp. Office

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V		\$			\$	\$	1
2	V							2
3	V							3
4	V							4
5	V							5
6	V							6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	<b>Total</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	17 Salaries & Wages	\$	Lutheran Social Services of Illinois - Management Allocation	100.00%	\$ 394,105	\$	394,105	15
16	V	22 Empl Benefits & Taxes		Lutheran Social Services of Illinois - Management Allocation	100.00%	72,904		72,904	16
17	V	19 Prof Fees & Contracts		Lutheran Social Services of Illinois - Management Allocation	100.00%	33,132		33,132	17
18	V	21 Supplies, Telephone,		Lutheran Social Services of Illinois - Management Allocation	100.00%	23,091		23,091	18
19	V	34 Rental of Space		Lutheran Social Services of Illinois - Management Allocation	100.00%	47,962		47,962	19
20	V	5 Utilities		Lutheran Social Services of Illinois - Management Allocation	100.00%	2,476		2,476	20
21	V	6 Bldg Repairs & Maintenance		Lutheran Social Services of Illinois - Management Allocation	100.00%	7		7	21
22	V	32 Interest		Lutheran Social Services of Illinois - Management Allocation	100.00%	10,811		10,811	22
23	V	33 Real Estate Taxes		Lutheran Social Services of Illinois - Management Allocation	100.00%	18		18	23
24	V	26 Insurance		Lutheran Social Services of Illinois - Management Allocation	100.00%	18,935		18,935	24
25	V	27 Advertising & Promotions		Lutheran Social Services of Illinois - Management Allocation	100.00%	(18)		(18)	25
26	V	25 Transportation		Lutheran Social Services of Illinois - Management Allocation	100.00%	6,546		6,546	26
27	V	35 Car Rental		Lutheran Social Services of Illinois - Management Allocation	100.00%	503		503	27
28	V	24 Conferences & Conventions		Lutheran Social Services of Illinois - Management Allocation	100.00%	3,233		3,233	28
29	V	20 Subscriptions, Dues, Awards		Lutheran Social Services of Illinois - Management Allocation	100.00%	2,787		2,787	29
30	V	6 Furniture & Fixtures		Lutheran Social Services of Illinois - Management Allocation	100.00%				30
31	V	6 Machinery & Equipment		Lutheran Social Services of Illinois - Management Allocation	100.00%				31
32	V	35 Equipment Rental		Lutheran Social Services of Illinois - Management Allocation	100.00%	906		906	32
33	V	6 Equipment Repair & Maint.		Lutheran Social Services of Illinois - Management Allocation	100.00%	21,421		21,421	33
34	V	20 Employee Recruitment		Lutheran Social Services of Illinois - Management Allocation	100.00%				34
35	V	7 Security & Waste Removal		Lutheran Social Services of Illinois - Management Allocation	100.00%	2,420		2,420	35
36	V	21 All Other Miscellaneous		Lutheran Social Services of Illinois - Management Allocation	100.00%	14,722		14,722	36
37	V	30 Depreciation		Lutheran Social Services of Illinois - Management Allocation	100.00%	46,688		46,688	37
38	V	19 Management Fees	703,768	Lutheran Social Services of Illinois - Management Allocation				(703,768)	38
39	Total		\$ 703,768			\$ 702,649	\$ *	(1,119)	39

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	17 Salaries & Wages	\$	Lutheran Social Services of Illinois - Human Resource Alloc.	100.00%	\$ 102,953	\$	102,953	15
16	V	22 Empl Benefits & Taxes		Lutheran Social Services of Illinois - Human Resource Alloc.	100.00%	23,710		23,710	16
17	V	19 Prof Fees & Contracts		Lutheran Social Services of Illinois - Human Resource Alloc.	100.00%	43,234		43,234	17
18	V	21 Supplies, Telephone,		Lutheran Social Services of Illinois - Human Resource Alloc.	100.00%	3,779		3,779	18
19	V	34 Rental of Space		Lutheran Social Services of Illinois - Human Resource Alloc.	100.00%	2,317		2,317	19
20	V	5 Utilities		Lutheran Social Services of Illinois - Human Resource Alloc.	100.00%				20
21	V	6 Bldg Repairs & Maintenance		Lutheran Social Services of Illinois - Human Resource Alloc.	100.00%				21
22	V	32 Interest		Lutheran Social Services of Illinois - Human Resource Alloc.	100.00%	1,003		1,003	22
23	V	33 Real Estate Taxes		Lutheran Social Services of Illinois - Human Resource Alloc.	100.00%				23
24	V	26 Insurance		Lutheran Social Services of Illinois - Human Resource Alloc.	100.00%	307		307	24
25	V	27 Advertising & Promotions		Lutheran Social Services of Illinois - Human Resource Alloc.	100.00%				25
26	V	25 Transportation		Lutheran Social Services of Illinois - Human Resource Alloc.	100.00%	905		905	26
27	V	35 Car Rental		Lutheran Social Services of Illinois - Human Resource Alloc.	100.00%	57		57	27
28	V	24 Conferences & Conventions		Lutheran Social Services of Illinois - Human Resource Alloc.	100.00%	4,225		4,225	28
29	V	20 Subscriptions, Dues, Awards		Lutheran Social Services of Illinois - Human Resource Alloc.	100.00%	406		406	29
30	V	6 Furniture & Fixtures		Lutheran Social Services of Illinois - Human Resource Alloc.	100.00%				30
31	V	6 Machinery & Equipment		Lutheran Social Services of Illinois - Human Resource Alloc.	100.00%				31
32	V	35 Equipment Rental		Lutheran Social Services of Illinois - Human Resource Alloc.	100.00%				32
33	V	6 Equipment Repair & Maint.		Lutheran Social Services of Illinois - Human Resource Alloc.	100.00%	1,336		1,336	33
34	V	20 Employee Recruitment		Lutheran Social Services of Illinois - Human Resource Alloc.	100.00%	7,157		7,157	34
35	V	7 Security & Waste Removal		Lutheran Social Services of Illinois - Human Resource Alloc.	100.00%	3		3	35
36	V	21 All Other Miscellaneous		Lutheran Social Services of Illinois - Human Resource Alloc.	100.00%	72		72	36
37	V	30 Depreciation		Lutheran Social Services of Illinois - Human Resource Alloc.	100.00%	9,954		9,954	37
38	V	19 Human Resources Allocations	201,685	Lutheran Social Services of Illinois - Human Resource Alloc.				(201,685)	38
39	Total		\$ 201,685			\$ 201,418	\$ *	(267)	39

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	17 Salaries & Wages	\$	Lutheran Social Services of Illinois - Network Administration	100.00%	\$ 130,024	\$	130,024	15
16	V	22 Empl Benefits & Taxes		Lutheran Social Services of Illinois - Network Administration	100.00%	27,255		27,255	16
17	V	19 Prof Fees & Contracts		Lutheran Social Services of Illinois - Network Administration	100.00%	29,465		29,465	17
18	V	21 Supplies, Telephone,		Lutheran Social Services of Illinois - Network Administration	100.00%	5,081		5,081	18
19	V	34 Rental of Space		Lutheran Social Services of Illinois - Network Administration	100.00%				19
20	V	5 Utilities		Lutheran Social Services of Illinois - Network Administration	100.00%				20
21	V	6 Bldg Repairs & Maintenance		Lutheran Social Services of Illinois - Network Administration	100.00%				21
22	V	32 Interest		Lutheran Social Services of Illinois - Network Administration	100.00%	15,026		15,026	22
23	V	33 Real Estate Taxes		Lutheran Social Services of Illinois - Network Administration	100.00%				23
24	V	26 Insurance		Lutheran Social Services of Illinois - Network Administration	100.00%	380		380	24
25	V	27 Advertising & Promotions		Lutheran Social Services of Illinois - Network Administration	100.00%	60		60	25
26	V	25 Transportation		Lutheran Social Services of Illinois - Network Administration	100.00%	2,016		2,016	26
27	V	35 Car Rental		Lutheran Social Services of Illinois - Network Administration	100.00%				27
28	V	24 Conferences & Conventions		Lutheran Social Services of Illinois - Network Administration	100.00%	2,356		2,356	28
29	V	20 Subscriptions, Dues, Awards		Lutheran Social Services of Illinois - Network Administration	100.00%	1,666		1,666	29
30	V	6 Furniture & Fixtures		Lutheran Social Services of Illinois - Network Administration	100.00%				30
31	V	6 Machinery & Equipment		Lutheran Social Services of Illinois - Network Administration	100.00%				31
32	V	35 Equipment Rental		Lutheran Social Services of Illinois - Network Administration	100.00%	588		588	32
33	V	6 Equipment Repair & Maint.		Lutheran Social Services of Illinois - Network Administration	100.00%				33
34	V	20 Employee Recruitment		Lutheran Social Services of Illinois - Network Administration	100.00%				34
35	V	7 Security & Waste Removal		Lutheran Social Services of Illinois - Network Administration	100.00%				35
36	V	21 All Other Miscellaneous		Lutheran Social Services of Illinois - Network Administration	100.00%				36
37	V	30 Depreciation		Lutheran Social Services of Illinois - Network Administration	100.00%	1,762		1,762	37
38	V	19 Service Network Allocations	190,779	Lutheran Social Services of Illinois - Network Administration				(190,779)	38
39	Total		\$ 190,779			\$ 215,679	\$ *	24,900	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

**VII. RELATED PARTIES (continued)**

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	<b>Total</b>		\$			\$	\$ *	39

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

**VII. RELATED PARTIES (continued)**

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	<b>Total</b>		\$			\$	\$ *	39

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

**VII. RELATED PARTIES (continued)**

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	<b>Total</b>		\$			\$	\$ *	39

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

**VII. RELATED PARTIES (continued)**

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	<b>Total</b>		\$			\$	\$ *	39

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

**VII. RELATED PARTIES (continued)**

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	<b>Total</b>		\$			\$	\$ *	39

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

**VII. RELATED PARTIES (continued)**

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	<b>Total</b>		\$			\$	\$ *	39

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

Facility Name & ID Number P A Peterson Center for Health # 0021238 Report Period Beginning: 07/01/09 Ending: 06/30/10

VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference
						Hours	Percent	Description	Amount	
1	N/A								\$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13								TOTAL	\$	13

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number P A Peterson Center for Health

# 0021238

Report Period Beginning:

07/01/09

Ending: 06/30/10

**VIII. ALLOCATION OF INDIRECT COSTS**

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

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

Name of Related Organization \_\_\_\_\_

Street Address \_\_\_\_\_

City / State / Zip Code \_\_\_\_\_

Phone Number ( ) \_\_\_\_\_

Fax Number ( ) \_\_\_\_\_

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number P A Peterson Center for Health

# 0021238

Report Period Beginning:

07/01/09

Ending: 06/30/10

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	17	Salaries & Wages	Non-Capital Direct Costs	36,454,205	265	\$ 3,120,995	\$ 3,120,995	4,603,268	\$ 394,105	1
2	22	Empl Benefits & Taxes		36,454,205	265	577,344	4,603,268	4,603,268	72,904	2
3	19	Prof Fees & Contracts		36,454,205	265	262,382	4,603,268	4,603,268	33,132	3
4	21	Supplies, Telephone,		36,454,205	265	182,863	4,603,268	4,603,268	23,091	4
5		Postage, Out. Printing		36,454,205	265		4,603,268	4,603,268		5
6	34	Rental of Space		36,454,205	265	379,819	4,603,268	4,603,268	47,962	6
7	5	Utilities		36,454,205	265	19,607	4,603,268	4,603,268	2,476	7
8	6	Bldg Repairs & Maintenance		36,454,205	265	59	4,603,268	4,603,268	7	8
9	32	Interest		36,454,205	265	85,612	4,603,268	4,603,268	10,811	9
10	33	Real Estate Taxes		36,454,205	265	144	4,603,268	4,603,268	18	10
11	26	Insurance		36,454,205	265	149,947	4,603,268	4,603,268	18,935	11
12	27	Advertising & Promotions		36,454,205	265	(143)	4,603,268	4,603,268	(18)	12
13	25	Transportation		36,454,205	265	51,838	4,603,268	4,603,268	6,546	13
14	35	Car Rental		36,454,205	265	3,984	4,603,268	4,603,268	503	14
15	23	Conferences & Conventions		36,454,205	265	25,603	4,603,268	4,603,268	3,233	15
16	20	Subscriptions, Dues, Awards		36,454,205	265	22,070	4,603,268	4,603,268	2,787	16
17	21	Furniture & Fixtures		36,454,205	265		4,603,268	4,603,268		17
18	6	Machinery & Equipment		36,454,205	265		4,603,268	4,603,268		18
19	35	Equipment Rental		36,454,205	265	7,178	4,603,268	4,603,268	906	19
20	6	Equipment Repair & Maint.		36,454,205	265	169,637	4,603,268	4,603,268	21,421	20
21	20	Employee Recruitment		36,454,205	265		4,603,268	4,603,268		21
22	7	Security & Waste Removal		36,454,205	265	19,162	4,603,268	4,603,268	2,420	22
23	21	All Other Miscellaneous		36,454,205	265	116,590	4,603,268	4,603,268	14,722	23
24	30	Depreciation		36,454,205	265	369,734	4,603,268	4,603,268	46,688	24
25	TOTALS					\$ 5,564,425	\$ 3,120,995		\$ 702,649	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number P A Peterson Center for Health

# 0021238

Report Period Beginning:

07/01/09

Ending: 06/30/10

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	17	Salaries & Wages	56,594,127	247	\$ 945,144	\$ 945,144	6,164,694	\$ 102,953	1
2	22	Empl Benefits & Taxes	56,594,127	247	217,667		6,164,694	23,710	2
3	19	Prof Fees & Contracts	56,594,127	247	396,906		6,164,694	43,234	3
4	21	Supplies, Telephone,	56,594,127	247			6,164,694		4
5		Postage, Out. Printing	56,594,127	247	34,691		6,164,694	3,779	5
6	34	Rental of Space	56,594,127	247	21,271		6,164,694	2,317	6
7	5	Utilities	56,594,127	247			6,164,694		7
8	6	Bldg Repairs & Maintenance	56,594,127	247			6,164,694		8
9	32	Interest	56,594,127	247	9,206		6,164,694	1,003	9
10	33	Real Estate Taxes	56,594,127	247			6,164,694		10
11	26	Insurance	56,594,127	247	2,818		6,164,694	307	11
12	27	Advertising & Promotions	56,594,127	247			6,164,694		12
13	25	Transportation	56,594,127	247	8,306		6,164,694	905	13
14	35	Car Rental	56,594,127	247	524		6,164,694	57	14
15	23	Conferences & Conventions	56,594,127	247	38,790		6,164,694	4,225	15
16	20	Subscriptions, Dues, Awards	56,594,127	247	3,730		6,164,694	406	16
17	21	Furniture & Fixtures	56,594,127	247			6,164,694		17
18	6	Machinery & Equipment	56,594,127	247			6,164,694		18
19	35	Equipment Rental	56,594,127	247			6,164,694		19
20	6	Equipment Repair & Maint.	56,594,127	247	12,264		6,164,694	1,336	20
21	20	Employee Recruitment	56,594,127	247	65,704		6,164,694	7,157	21
22	7	Security & Waste Removal	56,594,127	247	26		6,164,694	3	22
23	21	All Other Miscellaneous	56,594,127	247	663		6,164,694	72	23
24	30	Depreciation	56,594,127	247	91,380		6,164,694	9,954	24
25	TOTALS				\$ 1,849,090	\$ 945,144		\$ 201,418	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number P A Peterson Center for Health

# 0021238

Report Period Beginning:

07/01/09

Ending: 06/30/10

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	17	Salaries & Wages	7,027,993	22	\$ 198,513	\$ 198,513	4,603,268	\$ 130,024	1
2	22	Empl Benefits & Taxes	7,027,993	22	41,612		4,603,268	27,255	2
3	19	Prof Fees & Contracts	7,027,993	22	44,985		4,603,268	29,465	3
4	21	Supplies, Telephone,	7,027,993	22	7,758		4,603,268	5,081	4
5		Postage, Out. Printing	7,027,993	22			4,603,268		5
6	34	Rental of Space	7,027,993	22			4,603,268		6
7	5	Utilities	7,027,993	22			4,603,268		7
8	6	Bldg Repairs & Maintenance	7,027,993	22			4,603,268		8
9	32	Interest	7,027,993	22	22,941		4,603,268	15,026	9
10	33	Real Estate Taxes	7,027,993	22			4,603,268		10
11	26	Insurance	7,027,993	22	580		4,603,268	380	11
12	27	Advertising & Promotions	7,027,993	22	91		4,603,268	60	12
13	25	Transportation	7,027,993	22	3,078		4,603,268	2,016	13
14	35	Car Rental	7,027,993	22			4,603,268		14
15	23	Conferences & Conventions	7,027,993	22	3,597		4,603,268	2,356	15
16	20	Subscriptions, Dues, Awards	7,027,993	22	2,543		4,603,268	1,666	16
17	21	Furniture & Fixtures	7,027,993	22			4,603,268		17
18	6	Machinery & Equipment	7,027,993	22			4,603,268		18
19	35	Equipment Rental	7,027,993	22	898		4,603,268	588	19
20	6	Equipment Repair & Maint.	7,027,993	22			4,603,268		20
21	20	Employee Recruitment	7,027,993	22			4,603,268		21
22	7	Security & Waste Removal	7,027,993	22			4,603,268		22
23	21	All Other Miscellaneous	7,027,993	22			4,603,268		23
24	30	Depreciation	7,027,993	22	2,690		4,603,268	1,762	24
25	TOTALS				\$ 329,286	\$ 198,513		\$ 215,679	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number P A Peterson Center for Health

# 0021238

Report Period Beginning:

07/01/09

Ending: 06/30/10

**VIII. ALLOCATION OF INDIRECT COSTS**

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

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

Name of Related Organization \_\_\_\_\_

Street Address \_\_\_\_\_

City / State / Zip Code \_\_\_\_\_

Phone Number ( ) \_\_\_\_\_

Fax Number ( ) \_\_\_\_\_

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number P A Peterson Center for Health

# 0021238

Report Period Beginning:

07/01/09

Ending: 06/30/10

**VIII. ALLOCATION OF INDIRECT COSTS**

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

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

Name of Related Organization \_\_\_\_\_

Street Address \_\_\_\_\_

City / State / Zip Code \_\_\_\_\_

Phone Number ( ) \_\_\_\_\_

Fax Number ( ) \_\_\_\_\_

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number P A Peterson Center for Health

# 0021238

Report Period Beginning:

07/01/09

Ending: 06/30/10

**VIII. ALLOCATION OF INDIRECT COSTS**

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

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

Name of Related Organization \_\_\_\_\_

Street Address \_\_\_\_\_

City / State / Zip Code \_\_\_\_\_

Phone Number ( ) \_\_\_\_\_

Fax Number ( ) \_\_\_\_\_

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number  P A Peterson Center for Health

#  0021238

Report Period Beginning:

07/01/09

Ending:  06/30/10

**VIII. ALLOCATION OF INDIRECT COSTS**

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

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

Name of Related Organization \_\_\_\_\_

Street Address \_\_\_\_\_

City / State / Zip Code \_\_\_\_\_

Phone Number ( ) \_\_\_\_\_

Fax Number ( ) \_\_\_\_\_

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number **P A Peterson Center for Health**

# **0021238** Report Period Beginning: **07/01/09** Ending: **06/30/10**

**VIII. ALLOCATION OF INDIRECT COSTS**

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number P A Peterson Center for Health

# 0021238

Report Period Beginning:

07/01/09

Ending: 06/30/10

**VIII. ALLOCATION OF INDIRECT COSTS**

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number

P A Peterson Center for Health

# 0021238

Report Period Beginning:

07/01/09

Ending:

06/30/10

**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		8	9	10									
						Name of Lender	Related**				Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
							YES							NO	Original				Balance
	<b>A. Directly Facility Related</b>																		
	<b>Long-Term</b>																		
1	Tax Exempt Bonds		X	Refinance of 1993 Bonds -		2/16/06	\$ 4,338,000	\$ 3,979,916	2/16/2028	0.0523	\$ 227,928	1							
2				Refinance Building Additions								2							
3												3							
4												4							
5	See Supplemental Schedule											5							
	<b>Working Capital</b>																		
6												6							
7												7							
8	See Supplemental Schedule											8							
9	TOTAL Facility Related						\$ 4,338,000	\$ 3,979,916			\$ 227,928	9							
	<b>B. Non-Facility Related*</b>																		
10	Allocate LSSI		X								26,840	10							
11												11							
12												12							
13	See Supplemental Schedule											13							
14	TOTAL Non-Facility Related						\$	\$			\$ 26,840	14							
15	TOTALS (line 9+line14)						\$ 4,338,000	\$ 3,979,916			\$ 254,768	15							

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

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

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

Facility Name & ID Number

P A Peterson Center for Health

# 0021238

Report Period Beginning:

07/01/09

Ending:

06/30/10

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

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

1	2	3	4	5	6	7	8	9	10											
										Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
											YES	NO				Original	Balance			
<b>A. Directly Facility Related</b>																				
<b>Long-Term</b>																				
1										1										
2										2										
3										3										
4										4										
5										5										
6										6										
7	<b>TOTAL Long-Term</b>									7										
<b>Working Capital</b>																				
8										8										
9										9										
10										10										
11										11										
12										12										
13										13										
14	<b>TOTAL Working Capital</b>									14										
<b>B. Non-Facility Related*</b>																				
15										15										
16										16										
17										17										
18										18										
19										19										
20	<b>TOTAL Non-Facility Related</b>									20										

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

(See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

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

(See instructions.)







Facility Name & ID Number P A Peterson Center for Health

# 0021238 Report Period Beginning:

07/01/09 Ending:

06/30/10

**X. BUILDING AND GENERAL INFORMATION:**

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

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

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

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

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?  YES  NO  
 If so, please complete the following:

1. Total Amount Incurred: \_\_\_\_\_ 2. Number of Years Over Which it is Being Amortized: \_\_\_\_\_  
 3. Current Period Amortization: \_\_\_\_\_ 4. Dates Incurred: \_\_\_\_\_

Nature of Costs: \_\_\_\_\_  
 (Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

**XI. OWNERSHIP COSTS:**

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1	<u>Facility</u>	<u>192,020</u>	<u>1985</u>	<u>\$ 8,455</u>	<u>1</u>
2					<u>2</u>
3	<b>TOTALS</b>	<b>192,020</b>		<b>\$ 8,455</b>	<b>3</b>

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name &amp; ID Number P A Peterson Center for Health

# 0021238

Report Period Beginning:

07/01/09

Ending:

06/30/10

**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	158	1942	1942	\$ 95,858	\$	40	\$	\$	\$ 95,858	4
5		1979	1979	5,596,922		40	139,923	139,923	4,337,031	5
6										6
7										7
8										8
<b>Improvement Type**</b>										
9	Various		1969	5,300		20			5,300	9
10	Various		1975	9,226		20			9,226	10
11	Various		1977	10,074		20			10,074	11
12	Various		1980	71,947		20	144	144	71,624	12
13	Various		1981	7,309		20			7,309	13
14	Various		1982	6,151		20			6,151	14
15	Various		1983	30,936		20			30,936	15
16	Various		1984	15,554		20			15,554	16
17	Various		1985	4,850		20			4,850	17
18	Various		1986	21,640		20			21,640	18
19	Various		1988	4,414		20			4,414	19
20	Various		1989	71,006		20			71,006	20
21	Various		1990	103,287		20	5,031	5,031	89,264	21
22	Various		1991	64,328		20			64,328	22
23	Various		1992	20,528		20			20,528	23
24	Various		1993	4,296		20			4,296	24
25	Various		1994	86,971		20			86,971	25
26	Various		1995	767,445		20	30,034	30,034	541,750	26
27	Various		1996	12,220		20			12,220	27
28	Various		1997	2,685		20	4	4	2,685	28
29	Various		1998	149,521		20	7,476	7,476	118,529	29
30	Various		1999	17,200		20	1	1	17,200	30
31	Various		2000	63,500		20	3,175	3,175	28,766	31
32	Various		2001	109,787		20	5,489	5,489	63,864	32
33	Various		2002	79,186		20	3,959	3,959	47,273	33
34	Various		2003	121,363		20	7,685	7,685	75,102	34
35	Various		2004	10,088		20	504	504	3,285	35
36	Various		2005	1,697,457		20	84,873		426,215	36

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

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

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37 Various	2006	\$ 371,882	\$	20	\$ 18,594	\$ 18,594	\$ 88,981	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67 Related Building Company (Pages 12F & 12G)								67
68 Related Party Allocations (Pages 12H & 12I)					58,404	(58,404)		68
69 Financial Statement Depreciation					548,039	(548,039)		69
70 TOTAL (lines 4 thru 69)		\$ 9,632,931	\$ 606,443		\$ 306,893	\$ (384,423)	\$ 6,382,230	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name &amp; ID Number P A Peterson Center for Health

# 0021238

Report Period Beginning:

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Ending:

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## 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	<b>Totals from Page 12A, Carried Forward</b>		\$ 9,632,931	\$ 606,443		\$ 306,893	\$ (299,550)	\$ 6,382,230	1
2	Ventillation Upgrade- Hvac	2007	160,919		20	8,046	8,046	40,230	2
3	Ventillation Upgrades- Hvac	2007	101,065		20	5,053	5,053	25,266	3
4	Ventilation Upgrades- Hvac	2007	103,120		20	5,156	5,156	25,780	4
5	3Rd Floor New Flooring	2007	21,341		20	1,067	1,067	4,268	5
6	1St Floor Dinning Rm Flooring	2007	3,598		20	180	180	720	6
7	Phase Iii Hvac & Fire Damper	2007	686,480		20	34,324	34,324	137,296	7
8	Fire Place For Third Floor	2007	2,149		20	107	107	430	8
9	Custom Valance-Lobby Area 2Nd Fl	2007	979		20	49	49	196	9
10	Wall & Window Treatments-3Rd Fl	2007	29,429		20	1,471	1,471	5,886	10
11	Landscaping	2007	9,982		20	499	499	1,996	11
12	Third Floor New Flooring*	2007	22,224		20	1,111	1,111	4,445	12
13	Recover Awning*	2007	5,790		20	290	290	1,158	13
14	Repair 3Rd Floor Patio Roof*	2007	1,000		20	50	50	200	14
15	Lobby Carpeting*	2007	10,945		20	547	547	2,189	15
16	Masonry And Caulking Repairs*	2007	3,835		20	192	192	767	16
17	Masonry And Caulking Repairs*	2007	3,835		20	192	192	767	17
18	New Controller And Thermostat On Chiller*	2007	4,525		20	226	226	905	18
19	Boiler Repair*	2007	4,624		20	231	231	925	19
20	Chiller Barrel	2007	45,804		20	2,290	2,290	6,871	20
21	Phase 3 Hvac Upgrade	2007	25,036		20	1,252	1,252	3,755	21
22	Phase 3 Hvac & Fire Damper	2007	9,405		20	470	470	1,411	22
23	Repair Of 3Rd Fl Patio Roof	2007	19,450		20	973	973	2,918	23
24	Refrigeration Repairs	2007	5,349		20	267	267	802	24
25	Alarm System Repairs	2007	3,135		20	157	157	470	25
26	Refrigeration Repairs	2007	3,249		20	162	162	487	26
27	Tuckpointing	2008	110,870		20	5,544	5,544	16,631	27
28	Lobby, & Dining Room Wallpaper And Cornices	2008	7,079		20	2,317	2,317	6,951	28
29	Wiring Of Blower Fans For Ventilation	2008	36,924		20	1,846	1,846	5,539	29
30	Carpet Tile & Wall Covering	2008	26,976		20	1,349	1,349	4,046	30
31	Idph Repairs- Fire Alarm System	2008	5,910		20	296	296	591	31
32	Idph Repairs- Lobby/Reception Area	2008	2,588		20	129	129	259	32
33	Phase 3 Hvac Medicare Bed Expansion	2008	53,034		20	2,652	2,652	5,303	33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 11,163,579	\$ 606,443		\$ 385,388	\$ (221,055)	\$ 6,691,687	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name &amp; ID Number P A Peterson Center for Health

# 0021238

Report Period Beginning:

07/01/09

Ending:

06/30/10

## 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	<b>Totals from Page 12B, Carried Forward</b>		\$ 11,163,579	\$ 606,443		\$ 385,388	\$ (221,055)	\$ 6,691,687	1
2	Front Door Repairs	2008	3,400		20	170	170	340	2
3	Chiller Repair	2008	2,625		20	131	131	263	3
4	Tuckpointing On 3 Balcony Walls	2009	4,590		20	230	230	459	4
5	Wallpaper Deposit	2009	3,679		20	184	184	368	5
6	3Rd Floor Renovation-Window Treatment	2009	2,679		20	134	134	268	6
7	3Rd Floor Renovations-Wallcovering	2009	11,036		20	552	552	1,104	7
8	Phase 3 Hvac Medicare Bed Expansion	2009	28,986		20	1,449	1,449	2,899	8
9	3Rd Floor Renovations-Overbed Lights	2009	8,437		20	422	422	844	9
10	3Rd Floor Renovations-Paint/Wallpaper	2009	8,770		20	439	439	877	10
11	3Rd Floor Renovations-Signes For Resident Rooms, Bathrooms	2009	1,407		20	70	70	141	11
12	3Rd Floor Renovations-Window Treatements	2009	8,035		20	402	402	804	12
13	3Rd Floor Renovations-Carpet Tile	2009	47,782		20	2,389	2,389	4,778	13
14	3Rd Floor Renovations-Painting/Wallcovering	2009	14,785		20	739	739	1,479	14
15	Catwalk Over Receiving Dock	2009	81,250		20	4,063	4,063	8,125	15
16	Repair Water Main	2009	3,255		20	163	163	326	16
17	Compressor	2009	37,526		20	1,876	1,876	1,876	17
18	Catwalk Repair	2009	7,322		20	366	366	366	18
19	Prep / Paint Walls, Sand / Stain Doors	2009	14,785		20	739	739	739	19
20	Installation Of Nurse Call System	2009	3,156		20	158	158	158	20
21	Boiler Repairs	2009	2,896		20	145	145	145	21
22	Bronze Pump 3In Flange	2009	2,983		20	149	149	149	22
23	Water Heater Repairs	2009	2,664		20	2,664	2,664	2,664	23
24	Service On Fire Alarm Sytem	2009	3,900		20	195	195	195	24
25	Air Compressor	2010	4,051		20	203	203	203	25
26	Wanderguard System	2010	11,200		20	560	560	560	26
27	Boiler Repair	2010	10,303		20	515	515	515	27
28	Paving/Striping Of Parking Lot	2010	7,523		20	376	376	376	28
29	Front Railing	2010	2,574		20	129	129	129	29
30	Bathroom Repairs	2010	3,639		20	182	182	182	30
31	Refrigeration Repairs	2010	2,696		20	135	135	135	31
32	A/C Repairs	2010	3,086		20	154	154	154	32
33									33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 11,514,599	\$ 606,443		\$ 405,470	\$ (200,973)	\$ 6,723,304	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 11,514,599	\$ 606,443		\$ 405,470	\$ (200,973)	\$ 6,723,304	1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34		\$ 11,514,599	\$ 606,443		\$ 405,470	\$ (200,973)	\$ 6,723,304	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 11,514,599	\$ 606,443		\$ 405,470	\$ (200,973)	\$ 6,723,304	1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34		\$ 11,514,599	\$ 606,443		\$ 405,470	\$ (200,973)	\$ 6,723,304	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	<b>Building Company Information</b>								1
2	<b>Buildings:</b>								2
3									3
4									4
5									5
6									6
7									7
8	<b>Leasehold Improvements:</b>								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

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$	\$		\$	\$	\$	1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34	TOTAL (12F & 12G lines 1 thru 33)	\$	\$		\$	\$	\$	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Related Party Information		\$	\$		\$	\$	\$	1
2	Buildings:								2
3									3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9									9
10									10
11	Allocation from LSSI			58,404			(58,404)		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

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
1							
2							
3							
4							
5							
6							
7							
8							
9							
10							
11							
12							
13							
14							
15							
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20							
21							
22							
23							
24							
25							
26							
27							
28							
29							
30							
31							
32							
33							
34	TOTAL (12H & 12I lines 1 thru 33)	\$	\$ 58,404		\$	\$ (58,404)	\$

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number P A Peterson Center for Health

# 0021238

Report Period Beginning:

07/01/09

Ending:

06/30/10

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 2,536,255	\$	\$ 248,501	\$ 248,501	10	\$ 1,742,349	71
72	Current Year Purchases	109,575		10,958	10,958	10	10,958	72
73	Fully Depreciated Assets	741,510				10	741,510	73
74								74
75	TOTALS	\$ 3,387,341	\$	\$ 259,459	\$ 259,459		\$ 2,494,816	75

D. Vehicle Depreciation (See instructions.)\*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76		Handicapped Bus 1991	1991	\$ 38,800	\$	\$	\$	5	\$ 38,800	76
77		2006 Chevy Turtle Top Bus	2006	96,576		19,315	19,315	5	77,261	77
78										78
79										79
80	TOTALS			\$ 135,376	\$	\$ 19,315	\$ 19,315		\$ 116,061	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)	\$ 15,045,771	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 606,443	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 684,244	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 77,801	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 9,334,181	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	Renovation of Assisted Living - 2001	\$ 880	\$	\$	86
87	Renovation of Assisted Living - 2001	4,363			87
88	Renovation of Assisted Living - 2001	2,129			88
89	95 Improvement CORF - 1995	30,219			89
90	Dodge Van - 1997	17,032			90
91	TOTALS	\$ 54,623	\$	\$	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: N/A

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

If NO, see instructions.  YES  NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5	Allocate LSSI				50,279			5
6								6
7	TOTAL				\$ 50,279			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: \$ 16,608 Description: See Attached Schedule

(Attach a schedule detailing the breakdown of movable equipment)

**C. Vehicle Rental (See instructions.)**

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Facility		\$	1,939	17
18	Allocate LSSI			560	18
19					19
20					20
21	TOTAL		\$	2,499	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. \_\_\_\_\_ /2011 \$ \_\_\_\_\_

13. \_\_\_\_\_ /2012 \$ \_\_\_\_\_

14. \_\_\_\_\_ /2013 \$ \_\_\_\_\_

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

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

**XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)**

**A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)**

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. <u>CLASSROOM PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
--	---	--

**B. EXPENSES**

**ALLOCATION OF COSTS (d)**

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

**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.
- SEE ACCOUNTANTS' COMPILATION REPORT**

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

	Service	1 Schedule V Line & Column Reference	2		3		4		6 Supplies (Actual or Allocated)	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)	
			Staff		Outside Practitioner (other than consultant)							
			Units of Service	Cost	Units	Cost						
1	Licensed Occupational Therapist	39 - 03	hrs	\$		\$	497,738	\$		\$	497,738	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs				172,565				172,565	2
3	Licensed Recreational Therapist		hrs									3
4	Licensed Physical Therapist	39 - 03	hrs				1,074,850				1,074,850	4
5	Physician Care		visits									5
6	Dental Care		visits									6
7	Work Related Program		hrs									7
8	Habilitation		hrs									8
9	Pharmacy	39 - 02	# of prescrpts					373,437			373,437	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs									10
11	Academic Education		hrs									11
12	Other (specify):											12
13	Other (specify): <u>See Supplemental</u>						348	209,121			209,469	13
14	<b>TOTAL</b>			\$		\$	1,745,501	\$	582,558	\$	2,328,059	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

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

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</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>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)		<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>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>24</b> *

\* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name &amp; ID Number P A Peterson Center for Health

# 0021238

Report Period Beginning: 07/01/09

Ending: 06/30/10

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	\$ 12,412,659	1
2	Discounts and Allowances for all Levels	(599,529)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 11,813,130	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	943,620	6
7	Oxygen	2,894	7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 946,514	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	2,282	13
14	Non-Patient Meals	10,528	14
15	Telephone, Television and Radio	22,546	15
16	Rental of Facility Space		16
17	Sale of Drugs	1,525	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	30	20
21	Other Medical Services	206,767	21
22	Laundry	30,257	22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 273,935	23
<b>D. Non-Operating Revenue</b>			
24	Contributions	16,138	24
25	Interest and Other Investment Income***		25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 16,138	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<u>See Supplemental Schedule</u>	35,625	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 35,625	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 13,085,342	30

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	2,083,437	31
32	Health Care	3,740,222	32
33	General Administration	3,388,139	33
<b>B. Capital Expense</b>			
34	Ownership	976,997	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	2,372,733	35
36	Provider Participation Fee	70,628	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 12,632,156	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	453,186	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 453,186	43

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

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

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

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

Facility Name & ID Number P A Peterson Center for Health

# 0021238

Report Period Beginning:

07/01/09

Ending:

06/30/10

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	1,628	1,958	\$ 73,134	\$ 37.35	1
2	Assistant Director of Nursing	1,643	1,957	69,097	35.31	2
3	Registered Nurses	37,830	41,360	1,125,610	27.21	3
4	Licensed Practical Nurses	36,550	40,164	876,524	21.82	4
5	CNAs & Orderlies	99,481	107,823	1,183,619	10.98	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	11,288	14,237	120,926	8.49	10
11	Social Service Workers	6,417	7,297	111,920	15.34	11
12	Dietician					12
13	Food Service Supervisor	8,732	9,949	154,153	15.49	13
14	Head Cook	3,767	3,907	37,727	9.66	14
15	Cook Helpers/Assistants	36,474	38,678	327,178	8.46	15
16	Dishwashers					16
17	Maintenance Workers	7,660	8,645	131,991	15.27	17
18	Housekeepers	18,707	20,785	174,366	8.39	18
19	Laundry	1,672	1,881	15,191	8.08	19
20	Administrator	1,680	1,962	81,203	41.39	20
21	Assistant Administrator	1,605	1,962	55,505	28.29	21
22	Other Administrative					22
23	Office Manager	1,688	1,923	44,381	23.08	23
24	Clerical	17,318	19,385	278,317	14.36	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					31
32	Other Health Care(specify)					32
33	Other(specify) See Supplemental	5,665	6,433	116,797	18.16	33
34	TOTAL (lines 1 - 33)	299,805	330,306	\$ 4,977,639 *	\$ 15.07	34

\* This total must agree with page 4, column 1, line 45.

\*\* See instructions.

B. CONSULTANT SERVICES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference		
35	Dietary Consultant	As Needed	\$ 13,406	01-03	35
36	Medical Director	As Needed	22,970	09-03	36
37	Medical Records Consultant	As Needed	1,083	10-03	37
38	Nurse Consultant	As Needed	2,847	10-03	38
39	Pharmacist Consultant	As Needed	100	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	As Needed	1,038	12-03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 41,444		49

C. CONTRACT NURSES

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

SEE ACCOUNTANTS' COMPILATION REPORT

**XIX. SUPPORT SCHEDULES**

A. Administrative Salaries			Ownership %	Amount	D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions		
Name	Function				Description	Amount	Description	Amount		
Peggy Holt	Administrator		\$ 81,203	Workers' Compensation Insurance	\$ 225,085	IDPH License Fee	\$			
Christine Hintsche	Assist Administrator		55,505	Unemployment Compensation Insurance	39,203	Advertising: Employee Recruitment		5,003		
				FICA Taxes	364,813	Health Care Worker Background Check		9,616		
				Employee Health Insurance	420,007	(Indicate # of checks performed <u>601</u> )				
				Employee Meals		Patient Background Checks				
				Illinois Municipal Retirement Fund (IMRF)*		Membership Dues		16,560		
				Disability Insurance	9,560	Subscriptions & Books		329		
				Life Insurance	8,113	Advertising		70,783		
				Pension Plan	106,698	Allocate LSSI		12,016		
				Allocate LSSI	123,869					
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 136,708	TOTAL (agree to Schedule V, line 22, col.8)			\$ 1,297,348	TOTAL (agree to Sch. V, line 20, col. 8)		\$ 43,524
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**			
Description			Amount	Description	Line #	Amount	Description	Amount		
			\$			\$	Out-of-State Travel	\$		
							In-State Travel			
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$				Seminar Expense	29,008		
C. Professional Services							Allocate LSSI			9,814
Vendor/Payee	Type		Amount				Entertainment Expense			( )
Baker Tilly Virchov Krause	Accounting Services		\$ 50,000	TOTAL			\$	TOTAL (agree to Sch. V, line 24, col. 8)		\$ 38,822
FR&R Healthcare Consulting	Accounting Services		14,895							
Bob Holt	Accounting Services		550							
Ivans	Computer Services		727							
Gary Anderson & Assoc.	Architectural Services		345							
Qqest Software Systems	Computer Services		854							
Allocate LSSI			1,096,232							
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 1,163,603							

\* Attach copy of IMRF notifications  
SEE ACCOUNTANTS' COMPILATION REPORT

\*\*See instructions.

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

(See instructions.)

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name &amp; ID Number P A Peterson Center for Health

# 0021238

Report Period Beginning: 07/01/09

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**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes  
If YES, give association name and amount. LSN - \$5,289
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? \_\_\_\_\_
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? \_\_\_\_\_
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes  
What was the average life used for new equipment added during this period? 10 Yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 30,024 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No  
If YES, give effective date of lease. \_\_\_\_\_
- (9) Are you presently operating under a sublease agreement? \_\_\_\_\_ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES \_\_\_\_\_ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.  
\_\_\_\_\_
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 70,628  
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ \_\_\_\_\_ Has any meal income been offset against related costs? Yes Indicate the amount. \$ 10,528
- (16) Travel and Transportation  
a. Are there costs included for out-of-state travel? No  
If YES, attach a complete explanation.  
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ \_\_\_\_\_  
c. What percent of all travel expense relates to transportation of nurses and patients? None  
d. Have vehicle usage logs been maintained? Yes  
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes  
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? Yes  
**g. Does the facility transport residents to and from day training? No**  
**Indicate the amount of income earned from providing such transportation during this reporting period.** \$ \_\_\_\_\_
- (17) Has an audit been performed by an independent certified public accounting firm? Yes  
Firm Name: Baker Tilly Virchow Krause, LLP
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? N/A  
Attach invoices and a summary of services for all architect and appraisal fees.