

Facility Name & ID Number P. A. Peterson Center For Health

0021238 Report Period Beginning: 07/01/11 Ending: 06/30/12

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	47,214	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5	29	Sheltered Care (SC)	29	10,614	5
6		ICF/DD 16 or Less			6
7	158	TOTALS	158	57,828	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	12,968	20,233	14,013	47,214	8	
9	SNF/PED					9	
10	ICF		2,441		2,441	10	
11	ICF/DD					11	
12	SC					12	
13	DD 16 OR LESS					13	
14	TOTALS	12,968	22,674	14,013	49,655	14	

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 85.87%

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 12,866

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: 06/30/2012 Fiscal Year: 06/30/2012

* 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: 07/01/11 Ending: 06/30/12

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	440,217	36,476	123,276	599,969		599,969		599,969		1
2	Food Purchase		426,926		426,926		426,926	(14,414)	412,512		2
3	Housekeeping	188,721	30,363		219,084		219,084		219,084		3
4	Laundry	5,392	3,455	233,437	242,284		242,284		242,284		4
5	Heat and Other Utilities			220,400	220,400		220,400	(24,061)	196,339		5
6	Maintenance	122,866	37,298	228,230	388,394		388,394	14,169	402,563		6
7	Other (specify):*							3,141	3,141		7
8	TOTAL General Services	757,196	534,518	805,343	2,097,057		2,097,057	(21,165)	2,075,892		8
	B. Health Care and Programs										
9	Medical Director			16,250	16,250		16,250		16,250		9
10	Nursing and Medical Records	3,445,116	115,815	26,802	3,587,733		3,587,733		3,587,733		10
10a	Therapy										10a
11	Activities	207,545	7,020		214,565		214,565		214,565		11
12	Social Services	193,002		7,938	200,940		200,940		200,940		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	3,845,663	122,835	50,990	4,019,488		4,019,488		4,019,488		16
	C. General Administration										
17	Administrative	176,909			176,909		176,909	704,675	881,584		17
18	Directors Fees										18
19	Professional Services			1,318,333	1,318,333		1,318,333	(1,128,535)	189,798		19
20	Dues, Fees, Subscriptions & Promotions			81,651	81,651		81,651	(35,238)	46,413		20
21	Clerical & General Office Expenses	346,608	44,724	78,504	469,836		469,836	43,737	513,573		21
22	Employee Benefits & Payroll Taxes			1,156,493	1,156,493		1,156,493	143,711	1,300,204		22
23	Inservice Training & Education										23
24	Travel and Seminar			16,046	16,046		16,046	10,609	26,655		24
25	Other Admin. Staff Transportation			12,700	12,700		12,700	14,009	26,709		25
26	Insurance-Prop.Liab.Malpractice			171,052	171,052		171,052	20,934	191,986		26
27	Other (specify):*										27
28	TOTAL General Administration	523,517	44,724	2,834,779	3,403,020		3,403,020	(226,098)	3,176,922		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	5,126,376	702,077	3,691,112	9,519,565		9,519,565	(247,263)	9,272,302		29

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			550,729	550,729		550,729	140,751	691,480			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			215,304	215,304		215,304	20,514	235,818			32
33	Real Estate Taxes			182,380	182,380		182,380		182,380			33
34	Rent-Facility & Grounds							66,099	66,099			34
35	Rent-Equipment & Vehicles			8,154	8,154		8,154	1,861	10,015			35
36	Other (specify):*			5,628	5,628		5,628		5,628			36
37	TOTAL Ownership			962,195	962,195		962,195	229,225	1,191,420			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		987,495	1,691,288	2,678,783		2,678,783		2,678,783			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			304,633	304,633		304,633		304,633			42
43	Other (specify):*	36,112			36,112		36,112	(36,112)				43
44	TOTAL Special Cost Centers	36,112	987,495	1,995,921	3,019,528		3,019,528	(36,112)	2,983,416			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	5,162,488	1,689,572	6,649,228	13,501,288		13,501,288	(54,150)	13,447,138			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	(14,414)	02		4
5	Telephone, TV & Radio in Resident Rooms	(26,490)	05		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	92,589	30		9
10	Interest and Other Investment Income	(23)	32		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	(50,948)	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	(54,833)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (54,119)		\$	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)	(31)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (31)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (54,150)		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	TOTAL (C): (sum of lines 38-46)			\$	47

BHF USE ONLY							
48		49		50		51	
							52

SEE ACCOUNTANTS' COMPILATION REPORT

P. A. Peterson Center For Health

Report Period Beginning: 07/01/11
 Ending: 06/30/12
 ID# 0021238

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Additional R&M	\$ 10,598	06	1
2	Marketing Salaries	(36,112)	43	2
3	Capitalized R&M	(17,268)	06	3
4	Health Trust Rebates	(12,051)	21	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
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20				20
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31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(54,833)		49

STATE OF ILLINOIS

Summary A

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

Report Period Beginning:

07/01/11

Ending:

06/30/12

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	(14,414)											(14,414)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities	(26,490)		2,429									(24,061)	5
6	Maintenance	(6,670)		19,429	1,398	12							14,169	6
7	Other (specify):*			3,139	2								3,141	7
8	TOTAL General Services	(47,574)		24,997	1,400	12							(21,165)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records													10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*													15
16	TOTAL Health Care and Programs													16
	C. General Administration													
17	Administrative			425,616	105,171	173,888							704,675	17
18	Directors Fees													18
19	Professional Services			(736,924)	(159,639)	(231,972)							(1,128,535)	19
20	Fees, Subscriptions & Promotions	(50,948)		4,111	9,588	2,011							(35,238)	20
21	Clerical & General Office Expenses	(12,051)		44,482	8,743	2,563							43,737	21
22	Employee Benefits & Payroll Taxes			83,057	24,637	36,017							143,711	22
23	Inservice Training & Education													23
24	Travel and Seminar			4,236	4,405	1,968							10,609	24
25	Other Admin. Staff Transportation			10,383	873	2,753							14,009	25
26	Insurance-Prop.Liab.Malpractice			20,164	406	364							20,934	26
27	Other (specify):*													27
28	TOTAL General Administration	(62,999)		(144,875)	(5,816)	(12,408)							(226,098)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(110,573)		(119,878)	(4,416)	(12,396)							(247,263)	29

STATE OF ILLINOIS

Summary B

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

Report Period Beginning:

07/01/11

Ending:

06/30/12

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	92,589		42,925	956	4,281							140,751	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(23)		11,520	911	8,106							20,514	32
33	Real Estate Taxes													33
34	Rent-Facility & Grounds			63,628	2,471								66,099	34
35	Rent-Equipment & Vehicles			1,795	66								1,861	35
36	Other (specify):*													36
37	TOTAL Ownership	92,566		119,868	4,404	12,387							229,225	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers													39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(36,112)											(36,112)	43
44	TOTAL Special Cost Centers	(36,112)											(36,112)	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(54,119)		(10)	(12)	(9)							(54,150)	45

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Page 6-Supplemental		See Page 6-Supplemental		See Page 6-Supplemental		

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V		\$			\$	\$	1
2	V							2
3	V							3
4	V							4
5	V							5
6	V							6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$			\$	\$ *	14

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

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%	\$ 425,616	\$ 425,616
16	V	22 Empl Benefits & Taxes		Lutheran Social Services of Illinois - Management Allocation	100.00%	83,057	83,057
17	V	19 Prof Fees & Contracts		Lutheran Social Services of Illinois - Management Allocation	100.00%	11,906	11,906
18	V	21 Supplies, Telephone,		Lutheran Social Services of Illinois - Management Allocation	100.00%	26,502	26,502
19	V	34 Rental of Space		Lutheran Social Services of Illinois - Management Allocation	100.00%	63,628	63,628
20	V	5 Utilities		Lutheran Social Services of Illinois - Management Allocation	100.00%	2,429	2,429
21	V	6 Bldg Repairs & Maintenance		Lutheran Social Services of Illinois - Management Allocation	100.00%	172	172
22	V	32 Interest		Lutheran Social Services of Illinois - Management Allocation	100.00%	11,520	11,520
23	V	33 Real Estate Taxes		Lutheran Social Services of Illinois - Management Allocation	100.00%		
24	V	26 Insurance		Lutheran Social Services of Illinois - Management Allocation	100.00%	20,164	20,164
25	V	20 Advertising & Promotions		Lutheran Social Services of Illinois - Management Allocation	100.00%	(49)	(49)
26	V	25 Transportation		Lutheran Social Services of Illinois - Management Allocation	100.00%	10,383	10,383
27	V	35 Car Rental		Lutheran Social Services of Illinois - Management Allocation	100.00%	957	957
28	V	24 Conferences & Conventions		Lutheran Social Services of Illinois - Management Allocation	100.00%	4,236	4,236
29	V	20 Subscriptions, Dues, Awards		Lutheran Social Services of Illinois - Management Allocation	100.00%	4,160	4,160
30	V	6 Furniture & Fixtures		Lutheran Social Services of Illinois - Management Allocation	100.00%		
31	V	6 Machinery & Equipment		Lutheran Social Services of Illinois - Management Allocation	100.00%		
32	V	35 Equipment Rental		Lutheran Social Services of Illinois - Management Allocation	100.00%	838	838
33	V	6 Equipment Repair & Maint.		Lutheran Social Services of Illinois - Management Allocation	100.00%	19,257	19,257
34	V	20 Employee Recruitment		Lutheran Social Services of Illinois - Management Allocation	100.00%		
35	V	7 Security & Waste Removal		Lutheran Social Services of Illinois - Management Allocation	100.00%	3,139	3,139
36	V	21 All Other Miscellaneous		Lutheran Social Services of Illinois - Management Allocation	100.00%	17,980	17,980
37	V	30 Depreciation		Lutheran Social Services of Illinois - Management Allocation	100.00%	42,925	42,925
38	V	19 Management Fees	748,830	Lutheran Social Services of Illinois - Management Allocation	100.00%		(748,830)
39	Total		\$ 748,830			\$ 748,820	\$ * (10)

* 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%	\$ 105,171	\$	105,171	15
16	V	22 Empl Benefits & Taxes		Lutheran Social Services of Illinois - Human Resource Alloc.	100.00%	24,637		24,637	16
17	V	19 Prof Fees & Contracts		Lutheran Social Services of Illinois - Human Resource Alloc.	100.00%	42,925		42,925	17
18	V	21 Supplies, Telephone,		Lutheran Social Services of Illinois - Human Resource Alloc.	100.00%	4,358		4,358	18
19	V	34 Rental of Space		Lutheran Social Services of Illinois - Human Resource Alloc.	100.00%	2,471		2,471	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%	911		911	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%	406		406	24
25	V	20 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%	873		873	26
27	V	35 Car Rental		Lutheran Social Services of Illinois - Human Resource Alloc.	100.00%	66		66	27
28	V	24 Conferences & Conventions		Lutheran Social Services of Illinois - Human Resource Alloc.	100.00%	4,405		4,405	28
29	V	20 Subscriptions, Dues, Awards		Lutheran Social Services of Illinois - Human Resource Alloc.	100.00%	799		799	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%	1,398		1,398	33
34	V	20 Employee Recruitment		Lutheran Social Services of Illinois - Human Resource Alloc.	100.00%	8,789		8,789	34
35	V	7 Security & Waste Removal		Lutheran Social Services of Illinois - Human Resource Alloc.	100.00%	2		2	35
36	V	21 All Other Miscellaneous		Lutheran Social Services of Illinois - Human Resource Alloc.	100.00%	4,385		4,385	36
37	V	30 Depreciation		Lutheran Social Services of Illinois - Human Resource Alloc.	100.00%	956		956	37
38	V	19 Human Resources Allocations	202,564	Lutheran Social Services of Illinois - Human Resource Alloc.	100.00%			(202,564)	38
39	Total		\$ 202,564			\$ 202,552	\$ *	(12)	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%	\$ 173,888	\$ 173,888
16	V	22 Empl Benefits & Taxes		Lutheran Social Services of Illinois - Network Administration	100.00%	36,017	36,017
17	V	19 Prof Fees & Contracts		Lutheran Social Services of Illinois - Network Administration	100.00%	18,665	18,665
18	V	21 Supplies, Telephone,		Lutheran Social Services of Illinois - Network Administration	100.00%	2,563	2,563
19	V	34 Rental of Space		Lutheran Social Services of Illinois - Network Administration	100.00%		
20	V	5 Utilities		Lutheran Social Services of Illinois - Network Administration	100.00%		
21	V	6 Bldg Repairs & Maintenance		Lutheran Social Services of Illinois - Network Administration	100.00%		
22	V	32 Interest		Lutheran Social Services of Illinois - Network Administration	100.00%	8,106	8,106
23	V	33 Real Estate Taxes		Lutheran Social Services of Illinois - Network Administration	100.00%		
24	V	26 Insurance		Lutheran Social Services of Illinois - Network Administration	100.00%	364	364
25	V	20 Advertising & Promotions		Lutheran Social Services of Illinois - Network Administration	100.00%	62	62
26	V	25 Transportation		Lutheran Social Services of Illinois - Network Administration	100.00%	2,753	2,753
27	V	35 Car Rental		Lutheran Social Services of Illinois - Network Administration	100.00%		
28	V	24 Conferences & Conventions		Lutheran Social Services of Illinois - Network Administration	100.00%	1,968	1,968
29	V	20 Subscriptions, Dues, Awards		Lutheran Social Services of Illinois - Network Administration	100.00%	1,949	1,949
30	V	6 Furniture & Fixtures		Lutheran Social Services of Illinois - Network Administration	100.00%		
31	V	6 Machinery & Equipment		Lutheran Social Services of Illinois - Network Administration	100.00%		
32	V	35 Equipment Rental		Lutheran Social Services of Illinois - Network Administration	100.00%		
33	V	6 Equipment Repair & Maint.		Lutheran Social Services of Illinois - Network Administration	100.00%	12	12
34	V	20 Employee Recruitment		Lutheran Social Services of Illinois - Network Administration	100.00%		
35	V	7 Security & Waste Removal		Lutheran Social Services of Illinois - Network Administration	100.00%		
36	V	21 All Other Miscellaneous		Lutheran Social Services of Illinois - Network Administration	100.00%		
37	V	30 Depreciation		Lutheran Social Services of Illinois - Network Administration	100.00%	4,281	4,281
38	V	19 Service Network Allocations	250,637	Lutheran Social Services of Illinois - Network Administration	100.00%		(250,637)
39	Total		\$ 250,637			\$ 250,628	\$ * (9)

* 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	Total		\$			\$	\$ *	39

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: 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	Total		\$			\$	\$ *	39

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: 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	Total		\$			\$	\$ *	39

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: 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	Total		\$			\$	\$ *	39

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: 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	Total		\$			\$	\$ *	39

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

VII. RELATED PARTIES (continued)

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

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

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

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

Facility Name & ID Number

P. A. Peterson Center For Health

0021238

Report Period Beginning:

07/01/11

Ending:

06/30/12

VII. RELATED PARTIES

A. (Continued) Enter below the names of ALL owners and related organizations (parties) as defined in the instructions.

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	LSSI	100.000%	St. Matthew Center for Health	Park Ridge, IL	VESPER MANAGEMENT	DES PLAINES	MANAGEMENT CO.	1
2					LUTHERAN SOCIAL SERVICES	DES PLAINES	CORPORATE OFFICE	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

VII. RELATED PARTIES

A. (Continued) Enter below the names of ALL owners and related organizations (parties) as defined in the instructions.

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
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

Facility Name & ID Number P. A. Peterson Center For Health # 0021238 Report Period Beginning: 07/01/11 Ending: 06/30/12

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:

07/01/11

Ending: 06/30/12

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number P. A. Peterson Center For Health

0021238

Report Period Beginning:

07/01/11

Ending: 06/30/12

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	Non-Capital Direct Costs	36,642,160	308	\$ 3,150,086	\$ 4,950,818	\$ 425,616	1
2	22	Empl Benefits & Taxes		36,642,160	308	614,727	4,950,818	83,057	2
3	19	Prof Fees & Contracts		36,642,160	308	88,117	4,950,818	11,906	3
4	21	Supplies, Telephone,		36,642,160	308	196,147	4,950,818	26,502	4
5		Postage, Out. Printing		36,642,160	308		4,950,818		5
6	34	Rental of Space		36,642,160	308	470,928	4,950,818	63,628	6
7	5	Utilities		36,642,160	308	17,981	4,950,818	2,429	7
8	6	Bldg Repairs & Maintenance		36,642,160	308	1,271	4,950,818	172	8
9	32	Interest		36,642,160	308	85,265	4,950,818	11,520	9
10	33	Real Estate Taxes		36,642,160	308		4,950,818		10
11	26	Insurance		36,642,160	308	149,241	4,950,818	20,164	11
12	20	Advertising & Promotions		36,642,160	308	(360)	4,950,818	(49)	12
13	25	Transportation		36,642,160	308	76,850	4,950,818	10,383	13
14	35	Car Rental		36,642,160	308	7,081	4,950,818	957	14
15	24	Conferences & Conventions		36,642,160	308	31,352	4,950,818	4,236	15
16	20	Subscriptions, Dues, Awards		36,642,160	308	30,786	4,950,818	4,160	16
17	6	Furniture & Fixtures		36,642,160	308	3	4,950,818		17
18	6	Machinery & Equipment		36,642,160	308		4,950,818		18
19	35	Equipment Rental		36,642,160	308	6,204	4,950,818	838	19
20	6	Equipment Repair & Maint.		36,642,160	308	142,525	4,950,818	19,257	20
21	20	Employee Recruitment		36,642,160	308		4,950,818		21
22	7	Security & Waste Removal		36,642,160	308	23,233	4,950,818	3,139	22
23	21	All Other Miscellaneous		36,642,160	308	133,071	4,950,818	17,980	23
24	30	Depreciation		36,642,160	308	317,699	4,950,818	42,925	24
25	TOTALS					\$ 5,542,207	\$ 3,150,086	\$ 748,820	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number P. A. Peterson Center For Health

0021238

Report Period Beginning:

07/01/11

Ending: 06/30/12

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	60,293,424	269	\$ 1,003,501	\$ 1,003,501	6,318,978	\$ 105,171	1
2	22	Empl Benefits & Taxes	60,293,424	269	235,075		6,318,978	24,637	2
3	19	Prof Fees & Contracts	60,293,424	269	409,579		6,318,978	42,925	3
4	21	Supplies, Telephone,	60,293,424	269	41,579		6,318,978	4,358	4
5		Postage, Out. Printing	60,293,424	269			6,318,978		5
6	34	Rental of Space	60,293,424	269	23,578		6,318,978	2,471	6
7	5	Utilities	60,293,424	269			6,318,978		7
8	6	Bldg Repairs & Maintenance	60,293,424	269			6,318,978		8
9	32	Interest	60,293,424	269	8,692		6,318,978	911	9
10	33	Real Estate Taxes	60,293,424	269			6,318,978		10
11	26	Insurance	60,293,424	269	3,872		6,318,978	406	11
12	20	Advertising & Promotions	60,293,424	269			6,318,978		12
13	25	Transportation	60,293,424	269	8,326		6,318,978	873	13
14	35	Car Rental	60,293,424	269	627		6,318,978	66	14
15	24	Conferences & Conventions	60,293,424	269	42,031		6,318,978	4,405	15
16	20	Subscriptions, Dues, Awards	60,293,424	269	7,625		6,318,978	799	16
17	6	Furniture & Fixtures	60,293,424	269			6,318,978		17
18	6	Machinery & Equipment	60,293,424	269			6,318,978		18
19	35	Equipment Rental	60,293,424	269			6,318,978		19
20	6	Equipment Repair & Maint.	60,293,424	269	13,335		6,318,978	1,398	20
21	20	Employee Recruitment	60,293,424	269	83,861		6,318,978	8,789	21
22	7	Security & Waste Removal	60,293,424	269	20		6,318,978	2	22
23	21	All Other Miscellaneous	60,293,424	269	41,840		6,318,978	4,385	23
24	30	Depreciation	60,293,424	269	9,123		6,318,978	956	24
25	TOTALS				\$ 1,932,664	\$ 1,003,501		\$ 202,552	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number P. A. Peterson Center For Health

0021238

Report Period Beginning:

07/01/11

Ending: 06/30/12

VIII. ALLOCATION OF INDIRECT COSTS

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

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.

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	8,644,385	25	\$ 303,617	\$ 303,617	4,950,818	\$ 173,888	1
2	22	Empl Benefits & Taxes		8,644,385	25	62,887		4,950,818	36,017	2
3	19	Prof Fees & Contracts		8,644,385	25	32,590		4,950,818	18,665	3
4	21	Supplies, Telephone,		8,644,385	25	4,476		4,950,818	2,563	4
5		Postage, Out. Printing		8,644,385	25			4,950,818		5
6	34	Rental of Space		8,644,385	25			4,950,818		6
7	5	Utilities		8,644,385	25			4,950,818		7
8	6	Bldg Repairs & Maintenance		8,644,385	25			4,950,818		8
9	32	Interest		8,644,385	25	14,153		4,950,818	8,106	9
10	33	Real Estate Taxes		8,644,385	25			4,950,818		10
11	26	Insurance		8,644,385	25	636		4,950,818	364	11
12	20	Advertising & Promotions		8,644,385	25	108		4,950,818	62	12
13	25	Transportation		8,644,385	25	4,807		4,950,818	2,753	13
14	35	Car Rental		8,644,385	25			4,950,818		14
15	24	Conferences & Conventions		8,644,385	25	3,436		4,950,818	1,968	15
16	20	Subscriptions, Dues, Awards		8,644,385	25	3,403		4,950,818	1,949	16
17	6	Furniture & Fixtures		8,644,385	25			4,950,818		17
18	6	Machinery & Equipment		8,644,385	25			4,950,818		18
19	35	Equipment Rental		8,644,385	25			4,950,818		19
20	6	Equipment Repair & Maint.		8,644,385	25	21		4,950,818	12	20
21	20	Employee Recruitment		8,644,385	25			4,950,818		21
22	7	Security & Waste Removal		8,644,385	25			4,950,818		22
23	21	All Other Miscellaneous		8,644,385	25			4,950,818		23
24	30	Depreciation		8,644,385	25	7,474		4,950,818	4,281	24
25	TOTALS					\$ 437,608	\$ 303,617		\$ 250,628	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number P. A. Peterson Center For Health

0021238

Report Period Beginning:

07/01/11

Ending: 06/30/12

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number P. A. Peterson Center For Health

0021238

Report Period Beginning:

07/01/11

Ending: 06/30/12

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number P. A. Peterson Center For Health

0021238

Report Period Beginning:

07/01/11

Ending: 06/30/12

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number P. A. Peterson Center For Health

0021238

Report Period Beginning:

07/01/11

Ending: 06/30/12

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number P. A. Peterson Center For Health

0021238 Report Period Beginning: 07/01/11 Ending: 06/30/12

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number P. A. Peterson Center For Health

0021238

Report Period Beginning:

07/01/11

Ending: 06/30/12

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number

P. A. Peterson Center For Health

0021238

Report Period Beginning:

07/01/11

Ending:

06/30/12

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
	A. Directly Facility Related																		
	Long-Term																		
1	Tax Exempt Bonds		X	Refinance of 1993 Bonds		2/16/2006	\$ 4,338,000	\$ 3,735,285	02/16/28	0.0523	\$ 215,304	1							
2												2							
3												3							
4												4							
5	See Supplemental Schedule											5							
	Working Capital																		
6												6							
7												7							
8	See Supplemental Schedule											8							
9	TOTAL Facility Related						\$ 4,338,000	\$ 3,735,285			\$ 215,304	9							
	B. Non-Facility Related*																		
10	Interest Income		X								(23)	10							
11	Allocate LSSI (Schedule VIII)		X								20,537	11							
12												12							
13	See Supplemental Schedule											13							
14	TOTAL Non-Facility Related						\$	\$			\$ 20,514	14							
15	TOTALS (line 9+line14)						\$ 4,338,000	\$ 3,735,285			\$ 235,818	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:

07/01/11

Ending:

06/30/12

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
	A. Directly Facility Related																			
	Long-Term																			
1							\$	\$			\$	1								
2												2								
3												3								
4												4								
5												5								
6												6								
7	TOTAL Long-Term																			
	Working Capital																			
8							\$	\$			\$	8								
9												9								
10												10								
11												11								
12												12								
13												13								
14	TOTAL Working Capital																			
	B. Non-Facility Related*																			
15							\$	\$			\$	15								
16												16								
17												17								
18												18								
19												19								
20	TOTAL Non-Facility Related																			

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

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.)

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

B. Real Estate Taxes

		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.																	
1. Real Estate Tax accrual used on 2011 report.		\$	174,711	1															
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		\$	175,512	2															
3. Under or (over) accrual (line 2 minus line 1).		\$	801	3															
4. Real Estate Tax accrual used for 2012 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	181,579	4															
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$		5															
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$		6															
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	182,380	7															
Real Estate Tax History:																			
Real Estate Tax Bill for Calendar Year:	2007	149,208	8	<table border="1" style="width: 100%;"> <tr> <td colspan="2" style="text-align: center;">FOR BHF USE ONLY</td> </tr> <tr> <td style="text-align: center;">13</td> <td>FROM R. E. TAX STATEMENT FOR 2011 \$</td> <td style="text-align: center;">13</td> </tr> <tr> <td style="text-align: center;">14</td> <td>PLUS APPEAL COST FROM LINE 5 \$</td> <td style="text-align: center;">14</td> </tr> <tr> <td style="text-align: center;">15</td> <td>LESS REFUND FROM LINE 6 \$</td> <td style="text-align: center;">15</td> </tr> <tr> <td style="text-align: center;">16</td> <td>AMOUNT TO USE FOR RATE CALCULATION \$</td> <td style="text-align: center;">16</td> </tr> </table>		FOR BHF USE ONLY		13	FROM R. E. TAX STATEMENT FOR 2011 \$	13	14	PLUS APPEAL COST FROM LINE 5 \$	14	15	LESS REFUND FROM LINE 6 \$	15	16	AMOUNT TO USE FOR RATE CALCULATION \$	16
FOR BHF USE ONLY																			
13	FROM R. E. TAX STATEMENT FOR 2011 \$	13																	
14	PLUS APPEAL COST FROM LINE 5 \$	14																	
15	LESS REFUND FROM LINE 6 \$	15																	
16	AMOUNT TO USE FOR RATE CALCULATION \$	16																	
	2008	158,900	9																
	2009	171,731	10																
	2010	172,129	11																
	2011	175,512	12																
Payment is 2nd Half of 2010 - \$86,064 and 1st Half of 2011 - \$89,448																			
Ending Accruals per Client Record																			

NOTES:

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

SEE ACCOUNTANTS' COMPILATION REPORT

2011 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME P. A. Peterson Center For Health COUNTY Winnebago

FACILITY IDPH LICENSE NUMBER 0021238

CONTACT PERSON REGARDING THIS REPORT _____

TELEPHONE () _____ FAX #: () _____

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2011 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2011.

	(A)	(B)	(C)	(D)
	<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1.	<u>163B600 12-19-101-001</u>	<u>Long term Care Property</u>	\$ <u>175,511.87</u>	\$ <u>175,511.87</u>
2.	_____	_____	\$ _____	\$ _____
3.	_____	_____	\$ _____	\$ _____
4.	_____	_____	\$ _____	\$ _____
5.	_____	_____	\$ _____	\$ _____
6.	_____	_____	\$ _____	\$ _____
7.	_____	_____	\$ _____	\$ _____
8.	_____	_____	\$ _____	\$ _____
9.	_____	_____	\$ _____	\$ _____
10.	_____	_____	\$ _____	\$ _____
TOTALS			\$ <u>175,511.87</u>	\$ <u>175,511.87</u>

B. Real Estate Tax Cost Allocations

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

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

C. Tax Bills

Attach a copy of the original 2011 tax bills which were listed in Section A to this statement. Be sure to use the 2011 tax bill which is normally paid during 2012.

PLEASE NOTE: *Payment information from the Internet* or otherwise is *not considered acceptable tax bill documentation* . Facilities located in Cook County are required to provide copies of their original **second installment tax bill.**

Facility Name & ID Number P. A. Peterson Center For Health

0021238

Report Period Beginning:

07/01/11

Ending:

06/30/12

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	TOTALS	192,020		\$ 8,455	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number P. A. Peterson Center For Health

0021238

Report Period Beginning:

07/01/11

Ending:

06/30/12

XI. OWNERSHIP COSTS (continued)**B. Building and Improvement Costs-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	4,616,877	5
6											6
7											7
8											8
	Improvement Type**										
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	71,912	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	99,326	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	601,818	26
27	Various		1996		12,220		20			12,220	27
28	Various		1997		2,685		20			2,685	28
29	Various		1998		149,521		20	3,864	3,864	129,805	29
30	Various		1999		17,200		20			17,201	30
31	Various		2000		63,500		20	3,175	3,175	35,116	31
32	Various		2001		109,787		20	5,489	5,489	74,842	32
33	Various		2002		79,186		20	3,959	3,959	55,191	33
34	Various		2003		121,363		20	7,685	7,685	90,471	34
35	Various		2004		10,088		20	504	504	4,294	35
36	Various		2005		1,697,455		20	84,873		595,961	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 and Improvement Costs-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	\$ 126,169	37
38 Various	2007	1,287,268		20	64,363	64,363	398,864	38
39 Various	2008	249,406		20	12,244	12,244	64,411	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)			48,162			(48,162)		68
69 Financial Statement Depreciation			550,729			(550,729)		69
70 TOTAL (lines 4 thru 69)		\$ 11,169,603	\$ 598,891		\$ 379,883	\$ (303,881)	\$ 7,455,604	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number P. A. Peterson Center For Health

0021238

Report Period Beginning:

07/01/11

Ending:

06/30/12

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 11,169,603	\$ 598,891		\$ 379,883	\$ (219,008)	\$ 7,455,604	1
2	Tuckpointing On 3 Balcony Walls	2009	4,590		20	230	230	918	2
3	Wallpaper Deposit	2009	3,679		20	184	184	736	3
4	3Rd Floor Renovation-Window Treatment	2009	2,679		20	134	134	536	4
5	3Rd Floor Renovations-Wallcovering	2009	11,036		20	552	552	2,207	5
6	Phase 3 Hvac Medicare Bed Expansion	2009	28,986		20	1,449	1,449	5,797	6
7	3Rd Floor Renovations-Overbed Lights	2009	8,437		20	422	422	1,687	7
8	3Rd Floor Renovations-Paint/Wallpaper	2009	8,770		20	439	439	1,754	8
9	3Rd Floor Renovations-Signes For Resident Rooms, Bathrooms	2009	1,407		20	70	70	281	9
10	3Rd Floor Renovations-Window Treatments	2009	8,035		20	402	402	1,607	10
11	3Rd Floor Renovations-Carpet Tile	2009	47,782		20	2,389	2,389	9,556	11
12	3Rd Floor Renovations-Painting/Wallcovering	2009	14,785		20	739	739	2,957	12
13	Catwalk Over Receiving Dock	2009	81,250		20	4,063	4,063	16,250	13
14	Repair Water Main	2009	3,255		20	163	163	651	14
15	Compressor	2009	37,526		20	1,876	1,876	5,629	15
16	Catwalk Repair	2009	7,322		20	366	366	1,098	16
17	Prep / Paint Walls, Sand / Stain Doors	2009	14,785		20	739	739	2,218	17
18	Installation Of Nurse Call System	2009	3,156		20	158	158	473	18
19	Boiler Repairs	2009	2,896		20	145	145	434	19
20	Bronze Pump 3In Flange	2009	2,983		20	149	149	447	20
21	Water Heater Repairs	2009	2,664		20	266	266	798	21
22	Service On Fire Alarm Svtm	2009	3,900		20	195	195	585	22
23	Air Compressor	2010	4,051		20	203	203	608	23
24	Wanderguard System	2010	11,200		20	560	560	1,680	24
25	Boiler Repair	2010	10,303		20	515	515	1,545	25
26	Paving/Striping Of Parking Lot	2010	7,523		20	376	376	1,128	26
27	Front Railing	2010	2,574		20	129	129	386	27
28	Bathroom Repairs	2010	3,639		20	182	182	546	28
29	Refrigeration Repairs	2010	2,696		20	135	135	404	29
30	A/C Repairs	2010	3,086		20	154	154	463	30
31	Wander Guard Door Alarms-3Rd Fl	2010	5,000		20	500	500	1,000	31
32	Remove/Replace Damaged Guard Rail	2010	3,275		20	164	164	328	32
33	Repair Leak In Hot Water Pump	2010	2,679		20	134	134	268	33
34	TOTAL (lines 1 thru 33)		\$ 11,525,552	\$ 598,891		\$ 398,063	\$ (200,828)	\$ 7,520,582	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 and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 11,525,552	\$ 598,891		\$ 398,063	\$ (200,828)	\$ 7,520,582	1
2	Replace Radiator	2010	2,737		20	137	137	274	2
3	Install Teknofloor In 2Nd Floor Dining Room	2011	4,900		20	245	245	490	3
4	2Nd Floor Dining Room Renovations-Wallcoverings, Awnings	2011	16,068		20	803	803	1,607	4
5	Interior Lighting Upgrade	2011	22,147		20	1,107	1,107	2,215	5
6	Repair Hot Water Mixing Valve Nop	2011	4,527		20	226	226	453	6
7	100 Ton Chiller Compressor	2011	22,282		20	1,114	1,114	1,114	7
8	Cabling / Wireless Access	2011	10,250		20	512	512	512	8
9	Service To Fire Alarm	2011	3,235		20	162	162	162	9
10	Door & Hardware	2011	6,402		20	320	320	320	10
11	Replace Tubes On Boiler	2011	4,495		20	225	225	225	11
12	Mixing, Relief, Check Valves - Expanse Tank	2012	4,928		20	246	246	246	12
13	Electric Booster Heater	2012	2,720		20	136	136	136	13
14	Smoke Detectors / Horn & Strobe Lights	2012	11,618		20	581	581	581	14
15	Plumbing Below Concrete Floor In Kitchen	2012	30,702		20	1,535	1,535	1,535	15
16	Sewer Pipe Work Below Concrete Fl Kitchen	2012	38,557		20	1,928	1,928	1,928	16
17	Walk-In Cooler / Freezer	2012	17,633		20	882	882	882	17
18	Washable Panels-East Wall In Kitchen	2012	3,700		20	185	185	185	18
19	Architectural Services-Idph Tag-Kozo	2012	8,875		20	444	444	444	19
20	Exterior Brick Stone & Coping	2012	127,650		20	6,383	6,383	6,383	20
21	Chiller Staging Sequencer Repair	2012	3,136		20	157	157	157	21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 11,872,113	\$ 598,891		\$ 415,391	\$ (183,500)	\$ 7,540,429	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 and Improvement Costs-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		\$ 11,872,113	\$ 598,891		\$ 415,391	\$ (183,500)	\$ 7,540,429	1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34	TOTAL (lines 1 thru 33)	\$ 11,872,113	\$ 598,891		\$ 415,391	\$ (183,500)	\$ 7,540,429	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 and Improvement Costs-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		\$ 11,872,113	\$ 598,891		\$ 415,391	\$ (183,500)	\$ 7,540,429	1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34	TOTAL (lines 1 thru 33)	\$ 11,872,113	\$ 598,891		\$ 415,391	\$ (183,500)	\$ 7,540,429	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 and Improvement Costs-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 Building Company Information							
2 Buildings:							
3							
4							
5							
6							
7							
8 Leasehold Improvements:							
9							
10							
11							
12							
13							
14							
15							
16							
17							
18							
19							
20							
21							
22							
23							
24							
25							
26							
27							
28							
29							
30							
31							
32							
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 and Improvement Costs-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							
16							
17							
18							
19							
20							
21							
22							
23							
24							
25							
26							
27							
28							
29							
30							
31							
32							
33							
34	TOTAL (12F & 12G lines 1 thru 33)	\$	\$		\$	\$	\$

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 and Improvement Costs-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	LSSI Allocation (Schedule VIII)			48,162			(48,162)		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 and Improvement Costs-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 (12H & 12I lines 1 thru 33)		\$	\$ 48,162		\$	\$ (48,162)	\$	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-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	\$ 2,741,044	\$	\$ 268,921	\$ 268,921	10	\$ 2,285,827	71
72	Current Year Purchases	40,095		4,009	4,009	10	4,009	72
73	Fully Depreciated Assets	741,510				10	741,510	73
74								74
75	TOTALS	\$ 3,522,649	\$	\$ 272,931	\$ 272,931		\$ 3,031,346	75

D. Vehicle Costs. (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		2006 Chevy Turtle Top Bus	2006	\$ 96,576	\$	\$	\$	5	\$ 96,576	76
77		94 Chevrolet Pickup	2011	15,788		3,158	3,158	5	3,158	77
78										78
79										79
80	TOTALS			\$ 112,364	\$	\$ 3,158	\$ 3,158		\$ 99,733	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)	\$ 15,515,581	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 598,891	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 691,480	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 92,589	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 10,671,508	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	Architect Services	\$ 24,686	92
93			93
94			94
95		\$ 24,686	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 (Schedule VIII)			66,099			5
6							6
7	TOTAL			\$ 66,099			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: \$ 7,139 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		\$	\$ 1,853	17
18	Allocate LSSI (Schedule VIII)			1,023	18
19					19
20					20
21	TOTAL		\$	\$ 2,876	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. _____/2013 \$ _____

13. _____/2014 \$ _____

14. _____/2015 \$ _____

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

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

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

	Service	1 Schedule V Line & Column Reference	2		3		4		5	6	7	8		
			Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)						Total Cost (Col. 3 + 5 + 6)
			Units of Service	Cost	Units	Cost								
1	Licensed Occupational Therapist	39 - 03	hrs	\$		\$	569,862	\$			\$	569,862	1	
2	Licensed Speech and Language Development Therapist	39 - 03	hrs				119,394					119,394	2	
3	Licensed Recreational Therapist		hrs										3	
4	Licensed Physical Therapist	39 - 03	hrs				991,553					991,553	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						501,480			501,480	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>						10,479		486,015			496,494	13	
14	TOTAL			\$		\$	1,691,288	\$	987,495	\$		2,678,783	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

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of **06/30/12**

(last day of reporting year)

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

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

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

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

I. Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 12,438,840	1
2	Discounts and Allowances for all Levels	(266,532)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 12,172,308	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	603,536	6
7	Oxygen	224	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 603,760	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	2,059	13
14	Non-Patient Meals	14,414	14
15	Telephone, Television and Radio	19,475	15
16	Rental of Facility Space		16
17	Sale of Drugs	80	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	17	20
21	Other Medical Services	218,251	21
22	Laundry	21,238	22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 275,534	23
D. Non-Operating Revenue			
24	Contributions	87,090	24
25	Interest and Other Investment Income***	23	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 87,113	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	46,049	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 46,049	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 13,184,764	30

2

II. Expenses		Amount	
A. Operating Expenses			
31	General Services	2,097,057	31
32	Health Care	4,019,488	32
33	General Administration	3,403,020	33
B. Capital Expense			
34	Ownership	962,195	34
C. Ancillary Expense			
35	Special Cost Centers	2,714,895	35
36	Provider Participation Fee	304,633	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 13,501,288	40
41	Income before Income Taxes (line 30 minus line 40)**	(316,524)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (316,524)	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 1,715,417	44
45	Private Pay - Net Inpatient Revenue	5,737,585	45
46	Medicare - Net Inpatient Revenue	4,719,306	46
47	Other-(specify)		47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 12,172,308	49

* 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.

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number P. A. Peterson Center For Health

0021238

Report Period Beginning:

07/01/11

Ending:

06/30/12

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	1,618	1,959	\$ 78,102	\$ 39.87	1
2	Assistant Director of Nursing	1,670	1,849	69,541	37.61	2
3	Registered Nurses	44,121	46,704	1,283,119	27.47	3
4	Licensed Practical Nurses	35,089	36,486	797,476	21.86	4
5	CNAs & Orderlies	101,390	105,913	1,216,878	11.49	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	162	173	2,778	16.06	9
10	Activity Assistants	14,966	20,710	190,514	9.20	10
11	Social Service Workers	8,492	9,439	138,240	14.65	11
12	Dietician					12
13	Food Service Supervisor	4,351	4,591	63,484	13.83	13
14	Head Cook	7,747	7,965	81,308	10.21	14
15	Cook Helpers/Assistants	33,226	33,871	295,425	8.72	15
16	Dishwashers					16
17	Maintenance Workers	7,384	7,865	122,866	15.62	17
18	Housekeepers	20,085	21,324	188,721	8.85	18
19	Laundry	593	632	5,392	8.53	19
20	Administrator	1,808	2,025	92,348	45.60	20
21	Assistant Administrator	1,823	2,025	62,567	30.90	21
22	Other Administrative	667	838	21,994	26.25	22
23	Office Manager	3,450	3,936	85,427	21.70	23
24	Clerical	18,446	19,373	261,181	13.48	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	4,887	5,478	105,127	19.19	33
34	TOTAL (lines 1 - 33)	311,975	333,156	\$ 5,162,488 *	\$ 15.50	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	\$ 123,276	01-03	35
36	Medical Director	As Needed	16,250	09-03	36
37	Medical Records Consultant	As Needed	2,479	10-03	37
38	Nurse Consultant	As Needed	18,328	10-03	38
39	Pharmacist Consultant	As Needed	5,995	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	7,938	12-03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 174,266		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				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
Peggy Holt	Administrator	0	\$ 92,348	Workers' Compensation Insurance	\$ 151,103	IDPH License Fee	\$	
Christine Hintsche	Assist Administrator	0	62,567	Unemployment Compensation Insurance	25,935	Advertising: Employee Recruitment	4,263	
Vickie Beard	Administrative	0	11,987	FICA Taxes	378,810	Health Care Worker Background Check		
Victoria Engstrom-Goehry	Administrative	0	10,007	Employee Health Insurance	465,215	(Indicate # of checks performed <u>743</u>)	11,882	
				Employee Meals		Patient Background Checks		
				Illinois Municipal Retirement Fund (IMRF)*		Membership Dues	14,131	
				Disability Insurance	7,366	Subscriptions & Books	392	
				Life Insurance	6,341	Advertising	50,948	
				Pension Plan	121,723	Licenses	35	
				Allocate LSSI (Schedule VIII)	143,711	See Supplemental Schedule	15,710	
						Less: Public Relations Expense	()	
						Non-allowable advertising	(50,948)	
						Yellow page advertising	()	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 176,909	TOTAL (agree to Schedule V, line 22, col.8)	\$ 1,300,204	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 46,413	
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)			\$	TOTAL		\$	Seminar Expense	16,046
C. Professional Services							Allocate LSSI (Schedule VIII)	
Vendor/Payee	Type		Amount					10,609
FR&R	Accounting Services		\$ 5,840					
Pathway Health Services	Accounting Services		1,897					
Baker Tilly Virchow Krause	Accounting Services		75,000					
Qquest Software Systems	Computer Services		854					
Gary Anderson & Assoc.	Architectural Services		1,965					
See Attached	Legal		29,461					
Allocate LSSI			1,202,031					
MPRO	Conflict Resolution		1,285					
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 1,318,333				Entertainment Expense	()
							(agree to Sch. V, line 24, col. 8)	
							TOTAL	\$ 26,655

* 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
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1	N/A		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
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14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number P. A. Peterson Center For Health

0021238

Report Period Beginning: 07/01/11

Ending: 06/30/12

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-\$4,460
- (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. \$ 28,795 Line 10-02
- (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. N/A
- (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. \$ 304,633
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. \$ 0 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 14,414
- (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? Yes
Attach invoices and a summary of services for all architect and appraisal fees.

SEE ACCOUNTANTS' COMPILATION REPORT