

Facility Name & ID Number PETERSON PARK HLTH CARE CTR

0024463 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

III. STATISTICAL DATA

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

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

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	1,389	282	8,175	9,846	8
9	SNF/PED					9
10	ICF	47,861	4,944	187	52,992	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	49,250	5,226	8,362	62,838	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 91.57%

D. How many bed-hold days during this year were paid by the Department?

0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.

(E.g., day care, "meals on wheels", outpatient therapy)

NONE

F. Does the facility maintain a daily midnight census?

YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?

YES NO

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES NO

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

Date started 01/01/1978

J. Was the facility purchased or leased after January 1, 1978?

YES Date 12/86 NO

K. Was the facility certified for Medicare during the reporting year?

YES NO If YES, enter number of beds certified 93 and days of care provided 8,175

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: 12/31/2013 Fiscal Year: 12/31/2013

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

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	307,299	56,993	12,706	376,998		376,998	376,998		1	
2	Food Purchase		516,448		516,448	(68,620)	447,828	(4,129)	443,699	2	
3	Housekeeping	199,055	48,356	43,120	290,531		290,531	1,211	291,742	3	
4	Laundry	153,605	35,505	496	189,606		189,606		189,606	4	
5	Heat and Other Utilities			173,284	173,284		173,284	1,401	174,685	5	
6	Maintenance	60,350	90,011	62,387	212,748		212,748	3,842	216,590	6	
7	Other (specify):*			20,519	20,519		20,519		20,519	7	
8	TOTAL General Services	720,309	747,313	312,512	1,780,134	(68,620)	1,711,514	2,325	1,713,839	8	
	B. Health Care and Programs										
9	Medical Director			6,000	6,000		6,000		6,000	9	
10	Nursing and Medical Records	3,101,979	232,355	54,986	3,389,320		3,389,320	(36,350)	3,352,970	10	
10a	Therapy	181,328		86,312	267,640		267,640		267,640	10a	
11	Activities	178,614	20,838	6,000	205,452		205,452		205,452	11	
12	Social Services	59,086		3,176	62,262		62,262	6,278	68,540	12	
13	CNA Training									13	
14	Program Transportation			7,389	7,389		7,389	(3,202)	4,187	14	
15	Other (specify):*							308	308	15	
16	TOTAL Health Care and Programs	3,521,007	253,193	163,863	3,938,063		3,938,063	(32,966)	3,905,097	16	
	C. General Administration										
17	Administrative	187,752		1,786,594	1,974,346		1,974,346	(1,536,239)	438,107	17	
18	Directors Fees									18	
19	Professional Services			173,124	173,124		173,124	23,385	196,509	19	
20	Dues, Fees, Subscriptions & Promotions			127,500	127,500		127,500	(107,325)	20,175	20	
21	Clerical & General Office Expenses	271,088	65,844	393,080	730,012		730,012	(175,893)	554,119	21	
22	Employee Benefits & Payroll Taxes			817,187	817,187	68,620	885,807	(2,971)	882,836	22	
23	Inservice Training & Education			7,346	7,346		7,346		7,346	23	
24	Travel and Seminar							1,566	1,566	24	
25	Other Admin. Staff Transportation			7,790	7,790		7,790		7,790	25	
26	Insurance-Prop.Liab.Malpractice			7,015	7,015		7,015	197,352	204,367	26	
27	Other (specify):*			262,954	262,954		262,954	(216,446)	46,508	27	
28	TOTAL General Administration	458,840	65,844	3,582,590	4,107,274	68,620	4,175,894	(1,816,571)	2,359,323	28	
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,700,156	1,066,350	4,058,965	9,825,471		9,825,471	(1,847,212)	7,978,259	29	

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

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

V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE	SCHED REF	TOTAL
1	DIETARY	
	DIETITIAN CONSULTANT XVIII B 35-2	12,706
	REPAIRS & MAINTENANCE	0
		0
		12,706
3	HOUSEKEEPING	
	PROPERTY SPECIALIST - LEGACY	43,120
		0
		43,120
4	LAUNDRY	
	EQUIPMENT REPAIRS & MAINTENANCE	496
		0
		496
5	HEAT & OTHER UTILITIES	
	GAS HEAT	58,549
	ELECTRICITY	58,431
	WATER	48,467
	CABLE TV - LOBBY	7,837
		0
		173,284
6	MAINTENANCE	
	GROUNDS MAINTENANCE	15,899
	PAINTING & DECORATING	0
	BUILDING REPAIRS	0
	MAINTENANCE TRAVEL	0
	EQUIPMENT MAINTENANCE & REPAIR	33,550
	ELEVATOR MAINTENANCE & REPAIR	5,492
	OUTSIDE LABOR	0
	EXTERMINATING SERVICE	6,255
	FIRE SERVICE	1,191
		0
		0
		0
		0
		62,387
7	OTHER	
	SCAVENGER	15,271
	SECURITY SERVICE	5,248
		0
		0
		20,519
9	MEDICAL DIRECTOR	
	MEDICAL DIRECTOR FEES XVIII B 36-2	6,000
		6,000

LINE	SCHED REF	TOTAL
10	NURSING	
	CONTRACT NURSING XVIII C 53-2	
	LABORATORY & XRAY EXPENSE	9,831
	PURCHASED SERVICES	0
	PSYCHO-SOCIAL CONSULTANT XVIII B __-2	0
	RESTORATIVE NURSING CONSULTANT XVIII B 38-2	540
	MEDICAL RECORDS CONSULTANT XVIII B 37-2	1,568
	PHARMACY CONSULTANT XVIII B 39-2	13,987
	UTILIZATION REVIEW FEES XVIII B __-2	0
	PHYSICIANS XVIII B __-2	0
	PSYCHIATRIC XVIII B __-2	0
	RN CONSULTANT XVIII B 38-2	
	DENTAL & CLERGY	5,735
	LEGACY PROGRESSIVE	23,325
		54,986
10a	THERAPY	
	PHYSICAL THERAPY SERVICES	0
	SPEECH THERAPY SERVICES	0
	OCCUPATIONAL THERAPY SERVICES	0
	REHABILITATION CONSULTANT XVIII B __-2	0
	PHYSICAL THERAPY CONSULTANT XVIII B 40-2	0
	OCCUPATIONAL THERAPY CONSULTA XVIII B 41-2	0
	RESPIRATORY THERAPY CONSULTAN XVIII B 42-2	0
	SPEECH THERAPY CONSULTANT XVIII B 43-2	0
	NURSING PROGRAM CONSULTANT	62,312
	NURSING	24,000
		86,312
11	ACTIVITIES	
	CABLE TV - PATIENT ROOMS	0
	ACTIVITY REHAB CONSULTANT XVIII B 44-2	6,000
		0
		6,000
12	SOCIAL SERVICES	
	SOCIAL REHABILITATION SERVICES	0
	SOCIAL REHABILITATION CONSULTAN XVIII B 45-2	0
	SOCIAL WORKER XVIII B 45-2	3,176
		3,176
13	NURSE AIDE TRAINING	
	NURSE AIDE TRAINING COSTS XIII	0
		0

V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE		SCHED REF	TOTAL
14	PROGRAM TRANSPORTATION		
	PATIENT TRANSPORTATION		7,389
			0
17	ADMINISTRATIVE		
	MANAGEMENT FEES	XIX B	1,786,594
18	DIRECTORS FEES		
	DIRECTORS FEES		0
19	PROFESSIONAL SERVICES		
	DATA PROCESSING	XIX C	85,492
	ADMINISTRATIVE CONSULTANTS	XIX C	0
	PROFESSIONAL FEES	XIX C	87,632
			0
			173,124
20	FEES,SUBSCRIPTIONS,PROMOTIONS		
	ENTERTAINMENT & MARKETING	VI 19 XIX F	0
	ADV & PROMO-NON PATIENT RELATED	VI 25 XIX F	41,416
	EMPLOYEE WANT ADS	XIX F	852
	CONTRIBUTIONS	VI 20 XIX F	56,890
	DUES & SUBSCRIPTIONS	XIX F	10,951
	LICENSES & PERMITS	XIX F	3,464
	PUBLIC RELATIONS-PATIENT RELATED	XIX F	0
	ADVERTISING-YELLOW PAGES	VI 28 XIX F	0
	TRUST FEES / FRANCHISE TAX / ETC	VI 17 XIX F	0
	CONTRIBUTIONS - POLITICAL	VI 20 XIX F	9,972
	HEALTH CARE WORKER BACKGROUND CHEC	XIX F	3,955
	PATIENT BACKGROUND CHECKS	XIX F	0
			127,500
21	CLERICAL & GENERAL OFFICE EXPENSES		
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)		2,804
	EQUIPMENT REPAIR & MAINTENANCE		0
	OUTSIDE CLERICAL SERVICES		330,000
	PENALTIES / OVERDRAFT CHARGES	VI 18	1,531
	HOME OFFICE EXPENSE		0
	THEFT & DAMAGE LOSS		0
	TELEPHONE		26,459
	MESSENGER SERVICE		0
	LEGACY SPECIFIC SALARY		32,286
			393,080

LINE		SCHED REF	TOTAL
22	EMPLOYEE BENEFITS & PAYROLL TAXES		
	FICA TAXES	XIX D	354,819
	UNEMPLOYMENT COMPENSATION	XIX D	22,926
	WORKERS COMPENSATION INSURANC	XIX D	119,431
	HOSPITALIZATION INSURANCE	XIX D	235,225
	EMPLOYEE BENEFITS - OTHER	XIX D	49,116
	EMPLOYEE PHYSICAL EXAMS	XIX D	4,253
	INSURANCE - EXECUTIVE LIFE	VI 21/XIX D	2,971
	PENSION/PROFIT SHARING PLANS	XIX D	15,527
	CHICAGO HEAD TAX	XIX D	2,652
	PAYROLL TAXES - LEGACY		10,267
			817,187
23	INSERVICE TRAINING & EDUCATION		
	EDUCATION & SEMINARS		7,346
			7,346
24	TRAVEL & SEMINARS		
	EDUCATION & SEMINARS	XIX G	0
	TRAVEL	XIX G	0
			0
25	ADMIN. STAFF TRANSPORTATION		
	TRANSPORTATION - STAFF		7,790
			7,790
26	INSURANCE - PROP. LIAB & MALPRACTICE		
	GENERAL INSURANCE		7,015
			7,015
27	OTHER		
	BAD DEBTS	VI 24	262,954
			262,954

GRAND TOTAL COLUMN 3 OTHER

4,058,965

PETERSON PARK HLTH CARE CTR
SCHEDULES
12/31/2013

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

TOTAL FOOD PURCHASE	516,448
LESS SALES TAX	<u>(4,152)</u>
NET FOOD	512,296
TOTAL PATIENT CENSUS	62,838
TIMES 3 MEALS PER DAY	<u>3</u>
TOTAL PATIENT MEALS	188,514
ADD # EMPLOYEE MEALS/DAY	80
TIMES # DAYS	<u>365</u>
TOTAL EMPLOYEE MEALS	29,200
PATIENT MEALS	188,514
ADD EMPLOYEE MEALS	<u>29,200</u>
TOTAL MEALS/YEAR	217,714
NET FOOD	512,296
DIVIDE TOTAL MEALS/YEAR	<u>217,714</u>
COST PER MEAL	2.35
TIMES EMPLOYEE MEALS	<u>29,200</u>
EMPLOYEE MEAL RECLASSIFICATION	<u>68,620</u>

Facility Name & ID Number

PETERSON PARK HLTH CARE CTR

#0024463

Report Period Beginning:

01/01/2013

Ending:

12/31/2013

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			8,087	8,087	8,087	294,383	302,470				30
31	Amortization of Pre-Op. & Org.											31
32	Interest			3,821	3,821	3,821	55,986	59,807				32
33	Real Estate Taxes						258,245	258,245				33
34	Rent-Facility & Grounds			1,043,722	1,043,722	1,043,722	(1,043,722)					34
35	Rent-Equipment & Vehicles			18,917	18,917	18,917		18,917				35
36	Other (specify):*						26,596	26,596				36
37	TOTAL Ownership			1,074,547	1,074,547	1,074,547	(408,512)	666,035				37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		279,439	608,732	888,171	888,171		888,171				39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			443,988	443,988	443,988		443,988				42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		279,439	1,052,720	1,332,159	1,332,159		1,332,159				44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	4,700,156	1,345,789	6,186,232	12,232,177	12,232,177	(2,255,724)	9,976,453				45

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

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	120,215	30		9
10	Interest and Other Investment Income	(96,297)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(4,152)	2		13
14	Non-Care Related Interest		32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees		20		17
18	Fines and Penalties	(1,531)	21		18
19	Entertainment		20		19
20	Contributions	(66,862)	20		20
21	Owner or Key-Man Insurance	(2,971)	22		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(262,954)	27		24
25	Fund Raising, Advertising and Promotional	(41,416)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising		10		28
29	Other-Attach Schedule	(6,006)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (361,974)		\$	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)	(1,893,750)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (1,893,750)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B)	\$ (2,255,724)		37

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

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

		1	2	3	4	
		Yes	No	Amount	Reference	
38	Medically Necessary Transport.		X	\$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

BHF USE ONLY						
48		49		50		51
						52

PETERSON PARK HLTH CARE CTR

ID# 0024463

Report Period Beginning: 01/01/2013

Ending: 12/31/2013

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	BANK CHARGES	\$ (2,804)	21	1
2	DISALLOWED TRANSPORTATION		25	2
3	MARKETING SALARY		21	3
4	LIFELINE AMBULANCE	(3,202)	14	4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32

33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total		(6,006)	49

STATE OF ILLINOIS

Summary A

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

Report Period Beginning:

01/01/2013

Ending:

12/31/2013

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(4,152)	0	23	0	0	0	0	0	0	0	0	(4,129)	2
3	Housekeeping	0	0	1,211	0	0	0	0	0	0	0	0	1,211	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	1,401	0	0	0	0	0	0	0	0	1,401	5
6	Maintenance	0	0	3,842	0	0	0	0	0	0	0	0	3,842	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(4,152)	0	6,477	0	0	0	0	0	0	0	0	2,325	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	(36,350)	0	0	0	0	0	0	(36,350)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	6,278	0	0	0	0	0	0	6,278	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	(3,202)	0	0	0	0	0	0	0	0	0	0	(3,202)	14
15	Other (specify):*	0	0	0	0	308	0	0	0	0	0	0	308	15
16	TOTAL Health Care and Programs	(3,202)	0	0	0	(29,764)	0	0	0	0	0	0	(32,966)	16
	C. General Administration													
17	Administrative	0	0	(342,340)	0	16,459	(1,210,358)	0	0	0	0	0	(1,536,239)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	13,250	9,760	0	375	0	0	0	0	0	0	23,385	19
20	Fees, Subscriptions & Promotions	(108,278)	250	641	31	31	0	0	0	0	0	0	(107,325)	20
21	Clerical & General Office Expenses	(4,335)	0	(173,593)	0	2,035	0	0	0	0	0	0	(175,893)	21
22	Employee Benefits & Payroll Taxes	(2,971)	0	0	0	0	0	0	0	0	0	0	(2,971)	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	1,496	0	70	0	0	0	0	0	0	1,566	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	196,067	1,285	0	0	0	0	0	0	0	0	197,352	26
27	Other (specify):*	(262,954)	0	35,771	0	788	9,949	0	0	0	0	0	(216,446)	27
28	TOTAL General Administration	(378,538)	209,567	(466,980)	31	19,758	(1,200,409)	0	0	0	0	0	(1,816,571)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(385,892)	209,567	(460,503)	31	(10,006)	(1,200,409)	0	0	0	0	0	(1,847,212)	29

STATE OF ILLINOIS

Summary B

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

Report Period Beginning:

01/01/2013 Ending:

12/31/2013

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	120,215	166,945	2,969	4,254	0	0	0	0	0	0	0	294,383	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(96,297)	148,707	21	3,555	0	0	0	0	0	0	0	55,986	32
33	Real Estate Taxes	0	254,495	0	3,750	0	0	0	0	0	0	0	258,245	33
34	Rent-Facility & Grounds	0	(1,043,722)	11,226	(11,226)	0	0	0	0	0	0	0	(1,043,722)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	26,596	0	0	0	0	0	0	0	0	0	26,596	36
37	TOTAL Ownership	23,918	(446,979)	14,216	333	0	0	0	0	0	0	0	(408,512)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(361,974)	(237,412)	(446,287)	364	(10,006)	(1,200,409)	0	0	0	0	0	(2,255,724)	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
CHAIM RAJCHENBACH	5.32	THE GROVE AT LINCOLN PARK	CHICAGO	GROVE HC PROP	CHICAGO	REAL ESTATE
MENACHEM SHABAT	10.64	THE GROVE OF NORTHBROOK	CHICAGO	LEGACY HC		
JACK RAJCHENBACH	9.57	ASTORIA PLACE LIVING & REHAB CENTER	CHICAGO	FINANCIAL SERV	LINCOLNWOOD	MGMT
RONALD SHABAT	69.15	THE GROVE OF EVANSTON	EVANSTON	LEGACY REAL PRO	LINCOLNWOOD	REAL ESTATE
PPA, LTD.	5.32	ELMBROOK NURSING	ELMHURST	ASTORIA HEALTH		
		CHALET LIVING & REHAB	CHICAGO	CARE PROP	CHICAGO	REAL ESTATE
		LAKEFRONT NURSING	CHICAGO	EVANSTON HC RLT	EVANSTON	REAL ESTATE

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	34 RENT	\$ 1,043,722	PETERSON PARK REALTY		\$	\$ (1,043,722)	1
2	V							2
3	V	19 PROF FEES		PETERSON PARK REALTY		13,250	13,250	3
4	V	33 PROF. FEES - R/E REDUCTION		PETERSON PARK REALTY		12,348	12,348	4
5	V	20 LICENSES & FEES		PETERSON PARK REALTY		250	250	5
6	V	26 INSURANCE - GENERAL		PETERSON PARK REALTY		196,067	196,067	6
7	V	30 DEPRECIATION		PETERSON PARK REALTY		166,945	166,945	7
8	V	32 AMORT LOAN COSTS		PETERSON PARK REALTY		7,719	7,719	8
9	V	32 INTEREST		PETERSON PARK REALTY		140,988	140,988	9
10	V	33 REAL ESTATE TAXES		PETERSON PARK REALTY		242,147	242,147	10
11	V	36 INSURANCE H.U.D. (MIP)		PETERSON PARK REALTY		26,596	26,596	11
12	V							12
13	V							13
14	Total		\$ 1,043,722			\$ 806,310	\$ * (237,412)	14

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	17 MANAGEMENT FEES	\$ 376,236	LEGACY HEALTHCARE FINANCIAL SERVICES LLC		\$	\$ (376,236) 15
16	V	21 OUTSIDE CLERICAL	330,000	LEGACY HEALTHCARE FINANCIAL SERVICES LLC			(330,000) 16
17	V	2 FOOD		LEGACY HEALTHCARE FINANCIAL SERVICES LLC		23	23 17
18	V	3 HOUSEKEEPING		LEGACY HEALTHCARE FINANCIAL SERVICES LLC		1,211	1,211 18
19	V	5 UTILITIES		LEGACY HEALTHCARE FINANCIAL SERVICES LLC		1,401	1,401 19
20	V	6 GROUNDS & MAINTENANCE		LEGACY HEALTHCARE FINANCIAL SERVICES LLC		3,842	3,842 20
21	V	17 MANAGEMENT FEES		LEGACY HEALTHCARE FINANCIAL SERVICES LLC		33,896	33,896 21
22	V	19 PROFESSIONAL FEES		LEGACY HEALTHCARE FINANCIAL SERVICES LLC		9,760	9,760 22
23	V	20 FEES,SUBSCRIPTIONS		LEGACY HEALTHCARE FINANCIAL SERVICES LLC		641	641 23
24	V	21 CLERICAL & GENERAL		LEGACY HEALTHCARE FINANCIAL SERVICES LLC		156,407	156,407 24
25	V	24 SEMINARS		LEGACY HEALTHCARE FINANCIAL SERVICES LLC		1,496	1,496 25
26	V	26 INSURANCE		LEGACY HEALTHCARE FINANCIAL SERVICES LLC		1,285	1,285 26
27	V	27 EMPL BENEFITS-GEN ADMIN		LEGACY HEALTHCARE FINANCIAL SERVICES LLC		24,500	24,500 27
28	V	27 EMPL BENEFITS-OWNERS		LEGACY HEALTHCARE FINANCIAL SERVICES LLC		11,271	11,271 28
29	V	30 DEPRECIATION		LEGACY HEALTHCARE FINANCIAL SERVICES LLC		2,969	2,969 29
30	V	32 INTEREST		LEGACY HEALTHCARE FINANCIAL SERVICES LLC		21	21 30
31	V	34 RENT		LEGACY HEALTHCARE FINANCIAL SERVICES LLC		11,226	11,226 31
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 706,236			\$ 259,949	\$ * (446,287) 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	34 RENT	\$ 11,226	LEGACY REAL PROPERTIES LLC		\$	(11,226)	15
16	V	20 DUES AND SUBSCRIPTIONS		LEGACY REAL PROPERTIES LLC		31	31	16
17	V	30 DEPRECIATION		LEGACY REAL PROPERTIES LLC		4,254	4,254	17
18	V	32 INTEREST EXPENSE		LEGACY REAL PROPERTIES LLC		3,555	3,555	18
19	V	33 REAL ESTATE TAXES				3,750	3,750	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		\$ 11,226			\$ 11,590	\$ * 364	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	10 NURSE CONSULTANT	\$ 48,000	PROGRESSIVE HEALTHCARE CONSULTING		\$	\$ (48,000)
16	V	10 NURSING SALARIES		PROGRESSIVE HEALTHCARE CONSULTING		11,650	11,650
17	V	12 CLERGY SALARY		PROGRESSIVE HEALTHCARE CONSULTING		769	769
18	V	12 ADMISSIONS SALARY		PROGRESSIVE HEALTHCARE CONSULTING		5,509	5,509
19	V	15 EMPL BENEFIT- NURSING		PROGRESSIVE HEALTHCARE CONSULTING		308	308
20	V	17 ADMIN SAL-NON OWNERS		PROGRESSIVE HEALTHCARE CONSULTING		16,459	16,459
21	V	19 PROFESSIONAL FEES		PROGRESSIVE HEALTHCARE CONSULTING		375	375
22	V	20 FEES, SUBSCRIPTIONS		PROGRESSIVE HEALTHCARE CONSULTING		31	31
23	V	21 CLERICAL & GEN OFFICE		PROGRESSIVE HEALTHCARE CONSULTING		2,035	2,035
24	V	24 SEMINARS		PROGRESSIVE HEALTHCARE CONSULTING		70	70
25	V	27 AUTO AND TRAVEL		PROGRESSIVE HEALTHCARE CONSULTING		788	788
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 48,000			\$ 37,994	\$ * (10,006)

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	17 MANAGEMENT FEES	\$ 1,410,358	SHABAT & ASSOCIATES		\$	(1,410,358)
16	V	17 SALARY- RON SHABAT		SHABAT & ASSOCIATES		200,000	200,000
17	V	27 PAYROLL TAXES		SHABAT & ASSOCIATES		9,949	9,949
18	V						
19	V						
20	V						
21	V						
22	V						
23	V						
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 1,410,358			\$ 209,949	\$ * (1,200,409)

* 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	3	PROPERTY SPECIALIST	\$ 43,120	LEGACY HEALTHCARE FINANCIAL SERVICES LLC	\$ 43,120	\$
16	V	10	CLINICAL NURSE	9,174	PROGRESSIVE HEALTHCARE CONSULTING	9,174	
17	V	10	MDS COORDINATOR	746	PROGRESSIVE HEALTHCARE CONSULTING	746	
18	V	10	E.H.R. IMPLEMENTATION	13,405	PROGRESSIVE HEALTHCARE CONSULTING	13,405	
19	V	21	AR FIELD COORDINATOR	9,894	LEGACY HEALTHCARE FINANCIAL SERVICES LLC	9,894	
20	V	21	IN-HOUSE COUNSEL	10,451	LEGACY HEALTHCARE FINANCIAL SERVICES LLC	10,451	
21	V	21	CORPORATE IT DIRECTOR	3,409	LEGACY HEALTHCARE FINANCIAL SERVICES LLC	3,409	
22	V	21	CORPORATE TRAINOR	7,802	PROGRESSIVE HEALTHCARE CONSULTING	7,802	
23	V	21	PERSONNEL	730	LEGACY HEALTHCARE FINANCIAL SERVICES LLC	730	
24	V	22	PAYROLL TAXES	6,741	LEGACY HEALTHCARE FINANCIAL SERVICES LLC	6,741	
25	V	22	PAYROLL TAXES	3,325	PROGRESSIVE HEALTHCARE CONSULTING	3,325	
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 108,797			\$ 108,797	\$ *

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

Facility Name & ID Number

PETERSON PARK HLTH CARE CTR

0024463

Report Period Beginning:

01/01/2013

Ending:

12/31/2013

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			THE GROVE OF LAGRANGE	LAGRANGE PARK	ELMBROOK		REAL ESTATE	1
2			THE GROVE AT THE LAKE	ZION	HEALTHCARE RLTY	ELMHURST	REAL ESTATE	2
3			THE GROVE OF SKOKIE	SKOKIE	PETERSON PK RLTY	CHICAGO		3
4			PARK VILLA NURSING & REHAB	PALOS HEIGHTS	GROVE LAGRANGE		REAL ESTATE	4
5			THE VILLA AT WINDSOR PARK	CHICAGO	REALTY	LAGRANGE PK		5
6					GROVE AT THE		REAL ESTATE	6
7					LAKE REALTY	ZION		7
8					CHALET REAL		REAL ESTATE	8
9					PROPERTY	CHICAGO	REAL ESTATE	9
10					PARK VILLA RLTY	PALOS HGTS		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 PETERSON PARK HLTH CARE CTR # 0024463 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	RONALD SHABAT	OWNER	Administrative		SEE ATTACHED			Salary/Fees	\$ 95,714	17-7	1
2	RONALD SHABAT	OWNER	Administrative		SEE ATTACHED			P/R TAXES	1,388	27-7	2
3	CHAIM RAJCHENBACH	RELATIVE	Administrative		SEE ATTACHED			SALARY	16,948	17-7	3
4	MENACHEM SHABAT	OWNER	Administrative		SEE ATTACHED			SALARY	16,948	17-7	4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 130,998		13

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

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

Facility Name & ID Number PETERSON PARK HLTH CARE CTR

0024463

Report Period Beginning:

01/01/2013

Ending: 2/31/2013

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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					\$	\$		\$	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

Facility Name & ID Number PETERSON PARK HLTH CARE CTR

0024463

Report Period Beginning:

01/01/2013

Ending: 2/31/2013

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	2	FOOD	Bed Days Available	17	\$ 271	\$	68,620	\$ 23	1
2	3	HOUSEKEEPING	Bed Days Available	17	14,291	12,745	68,620	1,211	2
3	5	UTILITIES	Bed Days Available	17	16,531		68,620	1,401	3
4	6	GROUNDS & MAINTENANCE	Bed Days Available	17	45,337		68,620	3,842	4
5	17	MANAGEMENT FEES	Bed Days Available	17	400,000	400,000	68,620	33,896	5
6	19	PROFESSIONAL FEES	Bed Days Available	17	115,181		68,620	9,760	6
7	20	FEES,SUBSCRIPTIONS	Bed Days Available	17	7,563		68,620	641	7
8	21	CLERICAL & GENERAL	Bed Days Available	17	1,845,746	1,700,817	68,620	156,407	8
9	24	SEMINARS	Bed Days Available	17	17,652		68,620	1,496	9
10	26	INSURANCE	Bed Days Available	17	15,170		68,620	1,285	10
11	27	EMPL BENEFITS-GEN ADMIN	Bed Days Available	17	289,128		68,620	24,500	11
12	27	EMPL BENEFITS-OWNERS	Bed Days Available	17	133,004		68,620	11,271	12
13	30	DEPRECIATION	Bed Days Available	17	35,039		68,620	2,969	13
14	32	INTEREST	Bed Days Available	17	242		68,620	21	14
15	34	RENT	Bed Days Available	17	132,473		68,620	11,226	15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 3,067,628	\$ 2,113,562		\$ 259,949	25

Facility Name & ID Number PETERSON PARK HLTH CARE CTR

0024463

Report Period Beginning:

01/01/2013

Ending: 2/31/2013

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	20	DUES AND SUBSCRIPTIONS	Bed Days Available	809,780	17	\$ 368	68,620	\$ 31	1
2	30	DEPRECIATION	Bed Days Available	809,780	17	50,196	68,620	4,254	2
3	32	INTEREST EXPENSE	Bed Days Available	809,780	17	41,954	68,620	3,555	3
4	33	REAL ESTATE TAXES	Bed Days Available	809,780	17	44,250	68,620	3,750	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					\$ 136,768	\$	\$ 11,590	25

Facility Name & ID Number PETERSON PARK HLTH CARE CTR

0024463

Report Period Beginning:

01/01/2013

Ending: 2/31/2013

VIII. ALLOCATION OF INDIRECT COSTS

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

Name of Related Organization PROGRESSIVE HEALTHCARE CONSULTING
 Street Address 7040 RIDGEWAY
 City / State / Zip Code LINCOLNWOOD ILL 60712
 Phone Number (847) 679-9797
 Fax Number (847) 679-3676

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

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	10	NURSING SALARIES	Bed Days Available	550,071	11	\$ 93,385	\$ 93,385	68,620	\$ 11,650	1
2	12	CLERGY SALARY	Bed Days Available	550,071	11	6,165	6,165	68,620	769	2
3	12	ADMISSIONS SALARY	Bed Days Available	550,071	11	44,165	44,165	68,620	5,509	3
4	15	EMPL BENEFIT- NURSING	Bed Days Available	550,071	11	2,467		68,620	308	4
5	17	ADMIN SAL-NON OWNERS	Bed Days Available	550,071	11	131,937	131,937	68,620	16,459	5
6	19	PROFESSIONAL FEES	Bed Days Available	550,071	11	3,003		68,620	375	6
7	20	FEES, SUBSCRIPTIONS	Bed Days Available	550,071	11	250		68,620	31	7
8	21	CLERICAL & GEN OFFICE	Bed Days Available	550,071	11	16,314		68,620	2,035	8
9	24	SEMINARS	Bed Days Available	550,071	11	560		68,620	70	9
10	27	AUTO AND TRAVEL	Bed Days Available	550,071	11	6,314		68,620	788	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					\$ 304,560	\$ 275,652		\$ 37,994	25

Facility Name & ID Number PETERSON PARK HLTH CARE CTR

0024463

Report Period Beginning:

01/01/2013

Ending: 2/31/2013

VIII. ALLOCATION OF INDIRECT COSTS

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

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number

(847) 679-9797

Fax Number

(847) 679-3676

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	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

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	Name of Lender	2		3	4	5	6		8	9	10						
		Related**					Purpose of Loan	Monthly Payment Required				Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO										Original	Balance			
A. Directly Facility Related																	
Long-Term																	
1	RELATED PARTY: PETERSON PARK REALTY						\$	\$			\$	1					
2												2					
3	BEECH STREET		X	MORTGAGE	\$33,404.55	07/01/12	5,545,100	5,200,888	11/01/29	0.0265	140,988	3					
4												4					
5	LOAN COSTS		X	AMORTIZE OVER LIFE OF LOAN							7,719	5					
Working Capital																	
6	BANK FINANCIAL		X	LINE OF CREDIT				401,652			3,821	6					
7												7					
8	RELATED PARTY										3,576	8					
9	TOTAL Facility Related				\$33,404.55		\$ 5,545,100	\$ 5,602,540			\$ 156,104	9					
B. Non-Facility Related*																	
10	IRS, IDR, ETC		X	LATE FEES								10					
11												11					
12												12					
13												13					
14	TOTAL Non-Facility Related						\$	\$			\$	14					
15	TOTALS (line 9+line14)						\$ 5,545,100	\$ 5,602,540			\$ 156,104	15					

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 26,596 Line # 36

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

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

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

B. Real Estate Taxes

		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.				
1. Real Estate Tax accrual used on 2012 report.		\$	<u>229,675</u>		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.)		\$	<u>258,087</u>		2	
3. Under or (over) accrual (line 2 minus line 1).		\$	<u>28,412</u>		3	
4. Real Estate Tax accrual used for 2013 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	<u>254,337</u>		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.)		\$	<u>(36,852)</u>		6	
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	<u>245,897</u>		7	
Real Estate Tax History:						
Real Estate Tax Bill for Calendar Year:	2008	<u>214,298</u>	8	FOR BHF USE ONLY		
	2009	<u>221,013</u>	9			
	2010	<u>230,635</u>	10			
	2011	<u>233,727</u>	11			
	2012	<u>258,087</u>	12			
THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED ON ~ 100% OF THE PRIOR YEAR REAL ESTATE TAX BILL				13	FROM R. E. TAX STATEMENT FOR 2012 \$	13
THE PAYMENT ON LINE 2 APPLIES TO THE 2012 TAX BILL.				14	PLUS APPEAL COST FROM LINE 5 \$	14
				15	LESS REFUND FROM LINE 6 \$	15
				16	AMOUNT TO USE FOR RATE CALCULATION \$	16

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.

2012 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME PETERSON PARK HLTH CARE CTR COUNTY COOK

FACILITY IDPH LICENSE NUMBER 0024463

CONTACT PERSON REGARDING THIS REPORT SANFORD BOKOR

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

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2012 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 2012.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>13-02-115-052-0000</u>	<u>NURSING HOME</u>	\$ <u>254,337.32</u>	\$ <u>254,337.32</u>
2. _____	_____	\$ _____	\$ _____
3. <u>10-35-104-076-0000</u>	<u>HOME OFFICE ALLOCATION</u>	\$ <u>44,384.00</u>	\$ <u>3,750.00</u>
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u><u>298,721.32</u></u>	\$ <u><u>258,087.32</u></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 2012 tax bills which were listed in Section A to this statement. Be sure to use the 2012 tax bill which is normally paid during 2013.

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

X. BUILDING AND GENERAL INFORMATION:

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

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

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

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

N/A

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

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

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

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>FACILITY</u>			\$ <u>283,071</u>	1
2	<u>ALLOC FR LEGACY RP</u>			<u>6,933</u>	2
3	TOTALS			\$ 290,004	3

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	188	1986		\$ 2,548,850	\$ 126,369	35	\$ 72,824	\$ (53,545)	\$ 2,039,072	4
5										5
6										6
7										7
8										8
Improvement Type**										
9	VARIOUS		1979	4,800					4,800	9
10	VARIOUS		1981	57,728					57,728	10
11	VARIOUS		1982	11,967					11,967	11
12	VARIOUS		1983	3,440					3,440	12
13	VARIOUS		1984	12,700					12,700	13
14	VARIOUS		1985	98,707					98,707	14
15	VARIOUS		1986	42,087		31			42,087	15
16	VARIOUS		1987	17,729		31	572	572	15,306	16
17	VARIOUS		1988	35,577		31	1,147	1,147	29,056	17
18	VARIOUS		1989	14,591		31	470	470	11,469	18
19	VARIOUS		1990	27,693		31	894	894	20,607	19
20	VARIOUS		1991	62,352		20			62,352	20
21	VARIOUS		1992	10,152		20			10,152	21
22	VARIOUS		1993	21,815		20	1,092	1,092	22,499	22
23	VARIOUS		1994	264,384		20	13,226	13,226	254,680	23
24	VARIOUS		1995	103,507		20	5,176	5,176	95,515	24
25	VARIOUS		1996	35,086		20	1,757	1,757	30,851	25
26	VARIOUS		1997	62,950		20	3,150	3,150	51,650	26
27	VARIOUS		1998	49,698		20	2,487	2,487	39,085	27
28	VARIOUS		1999	87,532		20	4,383	4,383	64,945	28
29	VARIOUS		2000	188,443		20	9,427	9,427	127,492	29
30	VARIOUS		2001	73,918		20	3,700	3,700	46,882	30
31	VARIOUS		2002	350,099		20	17,508	17,508	201,328	31
32	VARIOUS		2003	78,238		20	3,908	3,908	41,058	32
33	VARIOUS		2004	66,172		20	3,309	3,309	31,412	33
34	VARIOUS		2005	53,841		20	2,693	2,693	22,573	34
35	VARIOUS		2006	50,608		20	2,531	2,531	18,974	35
36										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

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

0024463

Report Period Beginning:

01/01/2013

Ending:

12/31/2013

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			\$	\$		\$	\$	\$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 4,434,664	\$ 126,369		\$ 150,254	\$ 23,885	\$ 3,468,387	70

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

Facility Name & ID Number PETERSON PARK HLTH CARE CTR

0024463

Report Period Beginning:

01/01/2013

Ending:

12/31/2013

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	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 4,434,664	\$ 126,369		\$ 150,254	\$ 23,885	\$ 3,468,387	1
2	CONCRETE DOCK	2007	3,500		15	233	233	1,505	2
3	REHAB NURSING STATION	2007	11,394		20	570	570	3,705	3
4	RENOVATION 1ST FLOOR CORRIDOR AND LOBBY	2007	255,996		20	12,800	12,800	83,200	4
5	RENOVATION THERAPY REHAB ROOM	2007	12,744		20	637	637	4,141	5
6	SECURITY SYSTEM	2007	6,100		20	305	305	1,982	6
7	ROOF	2007	17,600		20	880	880	3,740	7
8	5 TON MULGIAGUA R-22 PACKGD ELECTRIC HIGH EFF	2007	32,940		20	1,647	1,647	10,706	8
9	CABLE WIRING	2007	12,500		20	625	625	4,062	9
10	NURSE CALL SYSTEM	2007	10,612		20	531	531	3,451	10
11	CIRCULATION OF HOT WATER LINES	2007	8,770		20	439	439	2,853	11
12	REAR ENTRANCE DOOR	2007	3,308		20	165	165	1,073	12
13	ELEVATOR REHAB 4 NEW NYLON PLATED GUILDE SHOES	2007	3,297		20	165	165	1,073	13
14	LANDSCAPING	2008	16,600		15	1,107	1,107	6,089	14
15	AWNING	2008	3,500		27.5	127	127	723	15
16	ELEVATOR REHAB	2008	5,500		27.5	200	200	1,138	16
17	ROOF	2008	4,000		27.5	145	145	825	17
18	COOPER PIPING	2008	2,860		27.5	104	104	592	18
19	CABLE WIRING	2008	3,850		27.5	140	140	796	19
20	A/C UNITS	2008	4,497		27.5	163	163	927	20
21	GATE VALVES	2008	2,800		27.5	102	102	580	21
22	NURSE CALL SYSTEM	2008	11,990		27.5	436	436	2,480	22
23	REPLACE HOT WATER & CIRCULATION LINES	2008	3,900		27.5	142	142	808	23
24	CABLE WIRING	2008	10,460		27.5	380	380	2,162	24
25	HOT WATER LINES	2008	7,500		27.5	273	273	1,553	25
26	A/C UNITS WITH SLEEVES	2008	3,951		27.5	144	144	819	26
27	BUILD IN WARDROBE CABINETS	2008	20,641		27.5	751	751	4,271	27
28	PAINTING	2009	39,906		20	1,995	1,995	11,971	28
29	SHADES, CORNICES & PANELS	2009	51,425		20	2,571	2,571	15,427	29
30	FLOORING & CARPETING	2009	5,410		20	271	271	1,625	30
31	WALLCOVERING, CORNICES & PANELS	2009	10,770		20	539	539	3,233	31
32	VINYL FLOORING	2009	5,481		20	274	274	1,644	32
33	SMOKE DETECTORS	2009	7,000		27.5	255	255	1,094	33
34	TOTAL (lines 1 thru 33)		\$ 5,035,466	\$ 126,369		\$ 179,370	\$ 53,001	\$ 3,648,635	34

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

Facility Name & ID Number PETERSON PARK HLTH CARE CTR

0024463

Report Period Beginning:

01/01/2013

Ending:

12/31/2013

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	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 5,035,466	\$ 126,369		\$ 179,370	\$ 53,001	\$ 3,648,635	1
2	GREASE TRAPS	2009	2,790		27.5	101	101	434	2
3	RECONDITION BOILER	2009	6,405		27.5	233	233	1,000	3
4	HOT WATER LINE	2009	5,180		27.5	188	188	807	4
5	WATER HEATER	2009	3,650		27.5	133	133	571	5
6	NURSE CALL SYSTEM	2009	21,666		27.5	788	788	3,382	6
7	HOT WATER & CIRCULATION LINE	2009	5,420		27.5	197	197	845	7
8	HOW WATER & CIRCULATION PIPES	2009	4,760		27.5	173	173	742	8
9	DRYWALL	2009	2,500		27.5	91	91	391	9
10	COPPER PIPING	2009	5,700		27.5	207	207	888	10
11	BATHROOM REMOD - LAVATORY, LIGHT FIX, WALL TOW	2009	12,407		27.5	451	451	1,936	11
12	CHAIR RAIL	2009	4,329		27.5	157	157	674	12
13	DRYWALL & DRAINS FOR 2 BATHTUBS	2009	5,600		27.5	204	204	875	13
14	PATIO	2009	10,390		15	693	693	3,032	14
15									15
16									16
17									17
18	DRYWALL METAL STUDS TIME & CONVERT TUB 2 SHOWI	2010	4,450		20	223	223	780	18
19	ROOM SIGNS	2010	12,108		20	605	605	2,118	19
20	CLINICAL SINKS	2010	7,121		20	356	356	1,246	20
21	PLUMBING IN UTILITY ROOM	2010	9,651		20	483	483	1,690	21
22	SIGN	2010	13,700		15	913	913	3,196	22
23	NURSES STATION - PANELS, BOARDS, GRANITE TOPS	2010	30,280		20	1,514	1,514	5,299	23
24	REHAB BATHROOM - ARCHITECT FEES	2010	4,170		20	209	209	731	24
25	REHAB BATHROOM - FAUCETS, LIGHTING, FLOORS	2010	32,452		20	1,623	1,623	5,680	25
26	CORRIDOR & DAY ROOM RENOV - COVE BASE, WINDOWS	2010	172,082		20	8,604	8,604	30,114	26
27	SOILDED UTILITY ROOM RENOVATION - CABINETS, SINK	2010	23,598		20	1,180	1,180	4,130	27
28	REHAB BATHROOMS - WALLS, LIGHTING, FLOORS	2010	77,780		20	3,889	3,889	13,612	28
29	CORRIDOR RENOVATION - WALLS, CHAIR RAILS, FLOOR	2010	172,732		20	8,637	8,637	30,229	29
30	TILING & WALLCOVERING FOR FOYER	2010	3,549		20	177	177	620	30
31	GENERATOR REPAIR	2010	2,526		20	126	126	441	31
32	THRU THE WALL HEATING & A/C UNITS	2010	5,626		20	281	281	984	32
33	SINKS & FAUCETS	2010	3,270		20	164	164	574	33
34	TOTAL (lines 1 thru 33)		\$ 5,701,358	\$ 126,369		\$ 211,970	\$ 85,601	\$ 3,765,656	34

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

Facility Name & ID Number PETERSON PARK HLTH CARE CTR

0024463

Report Period Beginning:

01/01/2013

Ending:

12/31/2013

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	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 5,701,358	\$ 126,369		\$ 211,970	\$ 85,601	\$ 3,765,656	1
2	TILING, PAINTING & REMODEL SOCIAL ROOM HALL OFF	2010	15,730		20	787	787	2,754	2
3	DRYWALL	2010	3,920		20	196	196	686	3
4	CHANGE LOCKS	2010	4,481		20	224	224	784	4
5	REMODEL PUBLIC BATHROOMS FLOOR WALL TOILET LI	2010	7,503		20	375	375	1,313	5
6	SHUT OFF VALVE & ACCESS PANELS IN SOILED UTLY RM	2010	3,994		20	200	200	700	6
7	REPLACE DRYWALL & STUDS IN BATHROOM	2010	2,930		20	147	147	514	7
8	REPLACE EXISTING TILE & BASEBOARDS & PAINT WALL	2010	9,990		20	499	499	1,747	8
9	REPLACE DRYWALL & STUDS & PAINTING	2010	7,918		20	396	396	1,386	9
10	REBUILT EJECTOR PUMP	2010	5,400		20	270	270	945	10
11	BATHROOM RESTORATION - WALLS & DRAINS	2010	9,350		20	468	468	1,638	11
12	RADIATOR HEATING SYSTEM	2010	9,590		20	480	480	1,680	12
13	HANDRAILS, BUMPERS, DOOR KNOBS	2010	4,350		20	218	218	763	13
14	TILING & BASEBOARDS, WALLS, CEILINGS, PAINT	2010	12,995		20	650	650	2,275	14
15	KITCHEN & EXHAUST FAN DUCTS, ELECTRICAL	2010	3,522		20	176	176	616	15
16	PAINTING & SINK IN MED ROOM	2010	6,470		20	324	324	1,134	16
17	DRYWALL, TILING, RAISING NURSE CALL SWITCHES	2010	4,050		20	203	203	710	17
18	PUMP REPAIRS/PUMP SEAL KIT	2010	2,642		20	132	132	462	18
19	ROOF - DRAINAGE	2010	2,600		20	130	130	455	19
20	DRAIN WATER LINE	2010	2,800		20	140	140	790	20
21	GLASS WALL/DOOR	2010	14,800		20	740	740	2,590	21
22	EMERGENCY/EXIT DOORS/DOOR OPENER	2010	4,200		20	210	210	735	22
23	ELECTRICAL & LIGHTING	2010	7,720		20	386	386	1,351	23
24	SIX WINDOWS	2010	3,000		20	150	150	525	24
25	HOT WATER TANK	2010	14,680		20	734	734	2,569	25
26	BEAUTY MIRROR INSTALLATION	2010	2,500		20	125	125	438	26
27									27
28	ARCHITECT FEES	2011	6,000		27.5	218	218	564	28
29	CUSTOM CABINETS BUILD IT SECURED TO WALL	2011	2,800		27.5	102	102	264	29
30	SEWER PUMP MOTOR	2011	2,910		27.5	106	106	274	30
31	ARCHITECT FEES	2011	6,474		27.5	235	235	607	31
32	BOILERS	2011	63,550		27.5	2,311	2,311	5,969	32
33	DOORS WINDOWS & THERMOBRAKE METAL	2011	16,100		27.5	585	585	1,219	33
34	TOTAL (lines 1 thru 33)		\$ 5,966,327	\$ 126,369		\$ 223,887	\$ 97,518	\$ 3,804,113	34

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

Facility Name & ID Number PETERSON PARK HLTH CARE CTR

0024463

Report Period Beginning:

01/01/2013

Ending:

12/31/2013

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 12D, Carried Forward		\$ 5,966,327	\$ 126,369		\$ 223,887	\$ 97,518	\$ 3,804,113	1
2	MILLWORK & TRIM	2011	2,600		27.5	94	94	148	2
3	ELECTRIAL WORK IN BOILER/ELECTRICAL ROOM	2011	7,800		27.5	284	284	450	3
4	SPRINKLER SYSTEM CONNECTION	2011	3,900		27.5	142	142	224	4
5	INSTALL 2 NEW DEDICATED CIRCUITS NEW WASH/DRYR	2011	2,800		27.5	102	102	162	5
6	HIGH EFFICENCY CONDENSER	2011	4,250		27.5	154	154	244	6
7	REPLACE KITCHEN TILE	2011	4,230		27.5	154	154	192	7
8	REPLACE KITCHEN TILE	2011	3,865		27.5	140	140	177	8
9	HOT WATER BOILER REPAIRS IN BASEMENT	2011	7,250		27.5	264	264	330	9
10	DRAIN LINE REPLACEMENT	2011	2,700		27.5	98	98	122	10
11	SECURITY KEYPAD & WIRING FOR ELEVATOR	2011	5,950		27.5	216	216	270	11
12	REPLACE KITCHEN TILE	2011	3,975		27.5	145	145	181	12
13	CONCRETE WORK	2011	19,140		15	1,276	1,276	2,552	13
14	CANOPYS	2011	14,890		15	993	993	1,987	14
15	LANDSCAPE IRRIGATION SYSTEM	2011	11,880		15	792	792	1,584	15
16	PLANT INSTALLATION	2011	19,030		15	1,269	1,269	2,539	16
17	CORNICES, BLINDS, SHEERS	2011	10,058		5	2,012	2,012	4,024	17
18	EJECTOR PUMP	2012	7,190		27.5	261	261	152	18
19	LOCKERS	2012	4,058		27.5	147	147	86	19
20	ELECTRICAL CIRCUIT	2012	3,225		27.5	117	117	68	20
21	exterior fire doors on both sides of building first floor, and								21
22	doors on the laundry shoot-first and second floor	2012	5,720		27.5	208	208	122	22
23	FIRE SPRINKLER	2012	3,990		27.5	145	145	84	23
24	window sill replacement on all windows on 1st & 2nd floor	2012	6,104		27.5	222	222	130	24
25	REPLACE METAL STUDS & DRYWALL IN STORAGE ROOM	2012	2,630		27.5	96	96	56	25
26	ELECTRIC WORK IN KITCHEN AREA	2012	2,970		27.5	108	108	62	26
27	REPLACED CRACKED DRAIN LINE	2012	2,580		27.5	94	94	54	27
28	HOT WATER BOILER	2012	84,380		27.5	3,068	3,068	1,790	28
29	REPLACED FASCIA GUTTERS,GRAVEL STOPPERS & ROOI	2012	17,900		27.5	651	651	380	29
30	TILE, NEW BASE LINER & CONCRETE BASE IN SHOWER	2012	6,320		27.5	230	230	134	30
31	NEW FIRE PANEL	2012	21,600		27.5	784	784	458	31
32	SCALD GUARD FOR SHOWERS	2012	6,663		27.5	242	242	142	32
33	ROOF-PATCH OPEN SEAMS, DRAINS AND FLESHING	2012	5,140		27.5	187	187	110	33
34	TOTAL (lines 1 thru 33)		\$ 6,271,115	\$ 126,369		\$ 238,582	\$ 112,213	\$ 3,823,127	34

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

Facility Name & ID Number PETERSON PARK HLTH CARE CTR

0024463

Report Period Beginning:

01/01/2013

Ending:

12/31/2013

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	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12E, Carried Forward		\$ 6,271,115	\$ 126,369		\$ 238,582	\$ 112,213	\$ 3,823,127	1
2	shower remodeling-new base liner,concrete base,tile install	2012	3,980		27.5	148	148	84	2
3	ELECTRIC WORK IN BOILER ROOM	2012	4,130		27.5	150	150	88	3
4	WALK IN FREEZER	2012	4,636		27.5	168	168	98	4
5	COMPRESSOR	2012	2,800		27.5	102	102	60	5
6	HORIZONTAL RAILING BARS FOR STAIRWAYS	2012	6,900		27.5	251	251	146	6
7	BOILER EXHAUST LINES	2012	7,200		27.5	262	262	152	7
8	GREASE TRAP	2012	4,200		27.5	153	153	90	8
9	TV OUTLETS	2012	11,445		27.5	416	416	242	9
10	DRYWALL, PATCH & SAND	2012	2,986		27.5	108	108	64	10
11	NEW PARKING LOT	2012	24,390		15	1,626	1,626	1,626	11
12	INSTALL WHOLE BUILDING EXHAUST FANS AND FIRE								12
13	DAMPERS, EXHAUST INLETS, AND GRILL COVERS								13
14	WITH ARCHITECT FEES	2013	109,727		27.5	2,161	2,161	2,161	14
15	HYDRONIC HEATING AND COOLING COIL RETROFITTED								15
16	INTO EXISTING AIR HANDLER AND CONNECTED TO								16
17	HYDRONIC HETING LINES ON KITCHEN AIR HANDLER	2013	10,897		27.5	215	215	215	17
18	RECEPTACLES IN VARIOUS LOCATIONS ON 1ST FLOOR	2013	7,034		27.5	138	138	138	18
19	VENTILATION SYSTEM	2013	2,641		27.5	36	36	36	19
20	RAILING BARS FOR EXISTING BALCONY	2013	6,650		27.5	91	91	91	20
21	KITCHEN DRAIN PIPING	2013	2,834		27.5	38	38	38	21
22	REPLACEMENT OF CEMENT BOARD , METAL STUDS AND								22
23	TILE BEHIND 3 COMPARTMENT SINK AND ON TWO								23
24	WALLS IN DISHWASHER ROOM	2013	7,320		27.5	100	100	100	24
25	CORNICES, BLINDS AND SHADES	2013	3,819		5	382	382	382	25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 6,494,704	\$ 126,369		\$ 245,127	\$ 118,758	\$ 3,828,938	34

**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	Totals from Page 12F, Carried Forward		\$ 6,494,704	\$ 126,369		\$ 245,127	\$ 118,758	\$ 3,828,938	1
2									2
3									3
4	RELATED PARTY INFORMATION								4
5	BUILDINGS:								5
6	ALLOCATED FROM LEGACY RP	2009	53,713	1,790	30	1,790			6
7									7
8									8
9									9
10	LEASED HOLD IMPROVEMENTS:								10
11	ALLOCATED FROM LEGACY RP	2009	30,503	763	20	1,525	762		11
12	ALLOCATED FROM LEGACY RP	2010	9,275	302	20	371	69		12
13	ALLOCATED FROM LEGACY RP	2011	13,183		20	659	659		13
14									14
15									15
16									16
17									17
18									18
19									19
20	ALLOCATED FROM LEGACY HEALTHCARE FINANCIAL	2012	2,416	254	20	121	(133)		20
21	ALLOCATED FROM LEGACY HEALTHCARE FINANCIAL	2013	10,145	1,066	20	628	(438)		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)		\$ 6,613,939	\$ 130,544		\$ 250,221	\$ 119,677	\$ 3,828,938	34

**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	\$ 398,178	\$ 16,138	\$ 39,818	\$ 23,680	10 YRS	\$ 182,928	71
72	Current Year Purchases	40,730	24,438	2,037	(22,401)	10 YRS	2,037	72
73	Fully Depreciated Assets	1,207,500					1,207,500	73
74	RELATED PARTY		3,048	2,307	(741)			74
75	TOTALS	\$ 1,646,408	\$ 43,624	\$ 44,162	\$ 538		\$ 1,392,465	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				\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 8,550,351	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 174,168	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 294,383	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 120,215	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 5,221,403	85

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

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

G. Construction-in-Progress

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

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: _____

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

If NO, see instructions. YES NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$ 1,043,722			3
4	Additions							4
5								5
6								6
7	TOTAL				\$ 1,043,722			7

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

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

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

12. _____ /2014 \$ _____

13. _____ /2015 \$ _____

14. _____ /2016 \$ _____

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: \$ 11,429 Description: SEE SCHEDULE ATTACHED

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$ 7,488	17
18					18
19					19
20					20
21	TOTAL		\$	\$ 7,488	21

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

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

Facility Name & ID Number PETERSON PARK HLTH CARE CTR # 0024463 Report Period Beginning: 01/01/2013 Ending: 12/31/2013
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>THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES</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.

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

	Service	1 Schedule V Line & Column Reference	2		3	4		5	6	7	8	
			Staff		Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)		
			Units of Service			Units	Cost					
1	Licensed Occupational Therapist	39-3	hrs	\$		\$	239,785	\$		\$	239,785	1
2	Licensed Speech and Language Development Therapist	39-3	hrs				133,257				133,257	2
3	Licensed Recreational Therapist		hrs									3
4	Licensed Physical Therapist	39-3	hrs				235,690				235,690	4
5	Physician Care		visits									5
6	Dental Care		visits									6
7	Work Related Program		hrs									7
8	Habilitation		hrs									8
9	Pharmacy	39-2	# of prescripts					279,439			279,439	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs									10
11	Academic Education		hrs									11
12	Other (specify):											12
13	Other (specify):											13
14	TOTAL			\$		\$	608,732	\$	279,439	\$	888,171	14

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

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

0024463

Report Period Beginning: **01/01/2013**

Ending:

12/31/2013

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of **12/31/2013**

(last day of reporting year)

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

		1 Operating	2 After Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$ 91,962	\$ 229,560	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (368,919))	1,576,451	1,576,451	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	54,339	212,613	6
7	Other Prepaid Expenses	304,239	816,768	7
8	Accounts Receivable (owners or related parties)	428,100	428,100	8
9	Other(specify): Medicare Co Ins Pass Thru			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,455,091	\$ 3,263,492	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		102,484	13
14	Buildings, at Historical Cost		2,548,850	14
15	Leasehold Improvements, at Historical Cost		3,804,093	15
16	Equipment, at Historical Cost		1,715,356	16
17	Accumulated Depreciation (book methods)		(5,450,736)	17
18	Deferred Charges		121,862	18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds		17,441	21
22	Other Long-Term Assets (specify):	104,460	104,460	22
23	Other(specify): due from pp realty	2,714,164		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 2,818,624	\$ 2,963,810	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 5,273,715	\$ 6,227,302	25

		1 Operating	2 After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 1,005,826	\$ 1,025,614	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	401,652	401,652	29
30	Accrued Salaries Payable	711,435	711,435	30
31	Accrued Taxes Payable (excluding real estate taxes)	26,352	26,352	31
32	Accrued Real Estate Taxes(Sch.IX-B)		254,337	32
33	Accrued Interest Payable		11,485	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 2,145,265	\$ 2,430,875	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable			39
40	Mortgage Payable		5,200,888	40
41	Bonds Payable			41
42	Deferred Compensation			42
Other Long-Term Liabilities(specify):				
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$ 5,200,888	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 2,145,265	\$ 7,631,763	46
47	TOTAL EQUITY(page 18, line 24)	\$ 3,128,450	\$ (1,404,461)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 5,273,715	\$ 6,227,302	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 4,775,212	1
2	Restatements (describe):		2
3	POST 2012 CLOSING ENTRY- BAD DEBTS DECREASE	100,003	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 4,875,215	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	532,690	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	(2,279,455)	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)	\$ (1,746,765)	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)	\$ 3,128,450	24 *

* This must agree with page 17, line 47.

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required

classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

		1	
I. Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 12,719,403	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 12,719,403	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	96,297	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 96,297	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 12,815,700	30

		2	
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	1,780,134	31
32	Health Care	3,938,063	32
33	General Administration	4,107,274	33
B. Capital Expense			
34	Ownership	1,074,547	34
C. Ancillary Expense			
35	Special Cost Centers	888,171	35
36	Provider Participation Fee	443,988	36
D. Other Expenses (specify):			
37	OTHER EXPENSE ADJUSTMENTS	2,104	37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 12,234,281	40
41	Income before Income Taxes (line 30 minus line 40)**	581,419	41
42	Income Taxes	(48,729)	42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 532,690	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 7,900,427	44
45	Private Pay - Net Inpatient Revenue	889,797	45
46	Medicare - Net Inpatient Revenue	3,744,348	46
47	Other-(specify) VETERAN	226,938	47
48	Other-(specify) INSURANCE	1,850	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 12,763,360	49

****TAX RETURN PREPARED ON CASH BASIS**

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

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

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

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

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

0024463

Report Period Beginning: **01/01/2013**

Ending:

12/31/2013

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	1,961	2,158	\$ 138,532	\$ 64.19	1
2	Assistant Director of Nursing	1,917	2,486	83,732	33.68	2
3	Registered Nurses	41,093	45,313	1,361,300	30.04	3
4	Licensed Practical Nurses	3,522	3,799	81,608	21.48	4
5	CNAs & Orderlies	95,584	102,421	1,133,620	11.07	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	9,180	9,996	181,328	18.14	8
9	Activity Director	1,806	2,084	29,522	14.17	9
10	Activity Assistants	11,686	12,749	149,092	11.69	10
11	Social Service Workers	3,298	3,627	59,086	16.29	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	20,712	22,205	307,299	13.84	15
16	Dishwashers					16
17	Maintenance Workers	3,680	3,889	60,350	15.52	17
18	Housekeepers	17,877	18,847	199,055	10.56	18
19	Laundry	11,625	12,707	153,605	12.09	19
20	Administrator	1,871	2,406	125,063	51.98	20
21	Assistant Administrator	1,277	1,868	62,689	33.56	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	12,401	13,594	149,802	11.02	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,487	1,658	40,169	24.23	31
32	Other Health Care(specify)	12,503	13,804	263,018	19.05	32
33	Other(specify) <u>ADMITTING</u>	8,612	9,470	121,286	12.81	33
34	TOTAL (lines 1 - 33)	262,092	285,081	\$ 4,700,156 *	\$ 16.49	34

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

** See instructions.

B. CONSULTANT SERVICES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference		
35	Dietary Consultant	M	\$ 12,706	1-3	35
36	Medical Director	O	6,000	9-3	36
37	Medical Records Consultant	N	1,568	10-3	37
38	Nurse Consultant	T	540	10-3	38
39	Pharmacist Consultant	H	13,987	10-3	39
40	Physical Therapy Consultant	L	0	10a-3	40
41	Occupational Therapy Consultant	Y	0	10a-3	41
42	Respiratory Therapy Consultant		0	10a-3	42
43	Speech Therapy Consultant	F	0	10a-3	43
44	Activity Consultant	E	6,000	11-3	44
45	Social Service Consultant	E	3,176	12-3	45
46	Other(specify) <u>Nursing Consultant</u>	S	24,000	10-3	46
47	<u>Nursing Program Consultant</u>		62,312	10-3	47
48	<u>Clergy & Dental</u>		5,735	10-3	48
49	TOTAL (lines 35 - 48)		\$ 136,024		49

C. CONTRACT NURSES

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

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	
ALICE OSHINSKI	ADMINISTRATOR	0	\$ 125,063	Workers' Compensation Insurance	\$ 119,431	IDPH License Fee	\$	
IGOR SHNEYDERMAN	ASST ADMIN	0	62,689	Unemployment Compensation Insurance	22,926	Advertising: Employee Recruitment	852	
	OTHER ADMIN		0	FICA Taxes	354,819	Health Care Worker Background Check	3,955	
				Employee Health Insurance	235,225	(Indicate # of checks performed)		
				Employee Meals	68,620	Patient Background Checks	0	
				Illinois Municipal Retirement Fund (IMRF)*		TRUST/FRANCHISE/CONTRIB/ETC	66,862	
				EMPLOYEE BENEFITS - OTHER	49,116	MARKETING/ADV/PROMO	41,416	
				EMPLOYEE PHYSICAL EXAMS	4,253	LICENSES/DUES/SUBSCRIPTIONS	14,415	
				PENSION/PROFIT SHARING PLANS	15,527	MGMT CO ALLOC	953	
				CHICAGO HEAD TAX	2,652	TRUST/FRANCHISE/CONTRIB/ETC	(66,862)	
				INSURANCE - EXECUTIVE LIFE	2,971	Less: Public Relations Expense	(0)	
				PAYROLL TAXES - LEGACY	10,267	Non-allowable advertising	(41,416)	
				INSURANCE - EXECUTIVE LIFE VI 21	(2,971)	Yellow page advertising	(0)	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 187,752	TOTAL (agree to Schedule V, line 22, col.8)	\$ 882,836	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 20,175	
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
SHABAT & ASSOCIATES			\$ 1,410,358			\$	Out-of-State Travel	\$
LEGACY HEALTHCARE			376,236					
							In-State Travel	0
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 1,786,594				Seminar Expense	0
							related party	1,566
C. Professional Services								
Vendor/Payee	Type		Amount	Description	Line #	Amount		
			\$			\$	Entertainment Expense	(
							(agree to Sch. V, line 24, col. 8)	
							TOTAL	\$ 1,566
SEE SCHEDULE ATTACHED			173,124	TOTAL		\$		
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 173,124					

* Attach copy of IMRF notifications

**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	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2												
3												
4												
5												
6												
7												
8												
9												
10												
11												
12												
13												
14												
15												
16												
17												
18												
19												
20	TOTALS	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

Facility Name & ID Number PETERSON PARK HLTH CARE CTR

0024463

Report Period Beginning: 01/01/2013 Ending: 12/31/2013

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? YES
- (2) Are there any dues to nursing home associations included on the cost report? YES
If YES, give association name and amount. IL COUNCIL ON LONG TERM CARE \$9,204
- (3) Did the nursing home make political contributions or payments to a political action organization? YES If YES, have these costs been properly adjusted out of the cost report? YES
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? YES
What was the average life used for new equipment added during this period? 10 YR
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ _____ Line 10-2
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? _____
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? _____ YES _____ NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO _____ If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 443,988
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. \$ 68,620 Has any meal income been offset against related costs? N/A Indicate the amount. \$ _____
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? NO
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? 5%
d. Have vehicle usage logs been maintained? NO
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? NO
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? YES
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? NO
Firm Name: _____
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? YES
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? YES
Attach invoices and a summary of services for all architect and appraisal fees.