

Facility Name & ID Number PETERSON PARK HEALTH CR CTR

0024463 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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			5,258	5,258	8
9	SNF/PED					9
10	ICF	52,258	3,710	1,482	57,450	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	52,258	3,710	6,740	62,708	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 91.38%

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 4,855

Medicare Intermediary NATIONAL GOVERNMENT SERVICE

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/2014 Fiscal Year: 12/31/2014

* 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	337,373	77,185	15,021	429,579		429,579	429,579			1
2	Food Purchase		555,038		555,038	(73,876)	481,162	(4,355)	476,807		2
3	Housekeeping	202,581	42,811		245,392		245,392	870	246,262		3
4	Laundry	141,741	61,168		202,909		202,909		202,909		4
5	Heat and Other Utilities			224,252	224,252		224,252	1,733	225,985		5
6	Maintenance	67,935	133,173	115,705	316,813		316,813	(33,913)	282,900		6
7	Other (specify):*			16,868	16,868		16,868		16,868		7
8	TOTAL General Services	749,630	869,375	371,846	1,990,851	(73,876)	1,916,975	(35,665)	1,881,310		8
	B. Health Care and Programs										
9	Medical Director			8,475	8,475		8,475		8,475		9
10	Nursing and Medical Records	3,043,938	239,180	174,828	3,457,946		3,457,946	(43,994)	3,413,952		10
10a	Therapy	161,629		1,983	163,612		163,612		163,612		10a
11	Activities	168,274	14,815	6,000	189,089		189,089	355	189,444		11
12	Social Services	172,542		8,870	181,412		181,412	4,087	185,499		12
13	CNA Training										13
14	Program Transportation			34,938	34,938		34,938	(3,905)	31,033		14
15	Other (specify):*							162	162		15
16	TOTAL Health Care and Programs	3,546,383	253,995	235,094	4,035,472		4,035,472	(43,295)	3,992,177		16
	C. General Administration										
17	Administrative	203,538		1,476,805	1,680,343		1,680,343	(1,197,035)	483,308		17
18	Directors Fees										18
19	Professional Services			251,762	251,762		251,762	32,414	284,176		19
20	Dues, Fees, Subscriptions & Promotions			186,648	186,648		186,648	(151,392)	35,256		20
21	Clerical & General Office Expenses	311,228	57,647	444,658	813,533		813,533	(189,404)	624,129		21
22	Employee Benefits & Payroll Taxes			928,086	928,086	73,876	1,001,962	(2,671)	999,291		22
23	Inservice Training & Education			4,527	4,527		4,527		4,527		23
24	Travel and Seminar							508	508		24
25	Other Admin. Staff Transportation			11,557	11,557		11,557	(9,218)	2,339		25
26	Insurance-Prop.Liab.Malpractice			2,510	2,510		2,510	226,681	229,191		26
27	Other (specify):*			354,586	354,586		354,586	(309,650)	44,936		27
28	TOTAL General Administration	514,766	57,647	3,661,139	4,233,552	73,876	4,307,428	(1,599,767)	2,707,661		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,810,779	1,181,017	4,268,079	10,259,875		10,259,875	(1,678,727)	8,581,148		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	14,189
	REPAIRS & MAINTENANCE	0
	LEGACY PROGRESSIVE	832
		15,021
3	HOUSEKEEPING	
	PROPERTY SPECIALIST - LEGACY	
		0
4	LAUNDRY	
	EQUIPMENT REPAIRS & MAINTENANCE	0
		0
5	HEAT & OTHER UTILITIES	
	GAS HEAT	87,910
	ELECTRICITY	72,247
	WATER	55,900
	CABLE TV - LOBBY	8,195
		224,252
6	MAINTENANCE	
	GROUNDS MAINTENANCE	22,876
	PAINTING & DECORATING	0
	BUILDING REPAIRS	16,324
	MAINTENANCE TRAVEL	0
	EQUIPMENT MAINTENANCE & REPAIR	62,054
	ELEVATOR MAINTENANCE & REPAIR	6,084
	OUTSIDE LABOR	0
	EXTERMINATING SERVICE	4,840
	FIRE SERVICE	3,527
		115,705
7	OTHER	
	SCAVENGER	14,516
	SECURITY SERVICE	2,352
		16,868
9	MEDICAL DIRECTOR	
	MEDICAL DIRECTOR FEES XVIII B 36-2	8,475
		8,475

LINE	SCHED REF	TOTAL
10	NURSING	
	CONTRACT NURSING XVIII C 53-2	
	LABORATORY & XRAY EXPENSE	10,898
	PURCHASED SERVICES	0
	PSYCHO-SOCIAL CONSULTANT XVIII B __-2	0
	RESTORATIVE NURSING CONSULTANT XVIII B 38-2	
	MEDICAL RECORDS CONSULTANT XVIII B 37-2	2,400
	PHARMACY CONSULTANT XVIII B 39-2	14,664
	UTILIZATION REVIEW FEES XVIII B __-2	0
	NURSING XVIII B __-2	24,000
	NURSING PROGRAM CONSULTANT XVIII B __-2	70,568
	CLERGY XVIII B 38-2	
	LAGACY PROGRESSIVE	52,298
		174,828
10a	THERAPY	
	PHYSICAL THERAPY SERVICES	0
	SPEECH THERAPY SERVICES	0
	OCCUPATIONAL THERAPY SERVICES	0
	REHABILITATION CONSULTANT XVIII B __-2	238
	PHYSICAL THERAPY CONSULTANT XVIII B 40-2	0
	OCCUPATIONAL THERAPY CONSULTA XVIII B 41-2	0
	RESPIRATORY THERAPY CONSULTAN XVIII B 42-2	1,745
	SPEECH THERAPY CONSULTANT XVIII B 43-2	0
		1,983
11	ACTIVITIES	
	CABLE TV - PATIENT ROOMS	0
	ACTIVITY REHAB CONSULTANT XVIII B 44-2	6,000
		6,000
12	SOCIAL SERVICES	
	SOCIAL REHABILITATION SERVICES	0
	SOCIAL REHABILITATION CONSULTAN XVIII B 45-2	0
	SOCIAL WORKER XVIII B 45-2	8,870
		8,870
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	34,938
		34,938
17	ADMINISTRATIVE	
	MANAGEMENT FEES & OTHER ADMIN FEES XIX B	1,476,805
18	DIRECTORS FEES	
	DIRECTORS FEES	0
19	PROFESSIONAL SERVICES	
	DATA PROCESSING XIX C	100,865
	ADMINISTRATIVE CONSULTANTS XIX C	
	PROFESSIONAL FEES XIX C	150,897
		251,762
20	FEES,SUBSCRIPTIONS,PROMOTIONS	
	ENTERTAINMENT & MARKETING VI 19 XIX F	12,670
	ADV & PROMO-NON PATIENT RELATED VI 25 XIX F	52,898
	EMPLOYEE WANT ADS XIX F	2,677
	CONTRIBUTIONS VI 20 XIX F	76,709
	DUES & SUBSCRIPTIONS XIX F	17,717
	LICENSES & PERMITS XIX F	5,100
	PUBLIC RELATIONS-PATIENT RELATED XIX F	0
	ADVERTISING-YELLOW PAGES VI 28 XIX F	1,000
	TRUST FEES / FRANCHISE TAX / ETC VI 17 XIX F	0
	CONTRIBUTIONS - POLITICAL VI 20 XIX F	8,611
	HEALTH CARE WORKER BACKGROUND CHEC XIX F	6,231
	PATIENT BACKGROUND CHECKS XIX F	3,035
		186,648
21	CLERICAL & GENERAL OFFICE EXPENSES	
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)	1,054
	EQUIPMENT REPAIR & MAINTENANCE	1,718
	OUTSIDE CLERICAL SERVICES	319,000
	PENALTIES / OVERDRAFT CHARGES VI 18	295
	HOME OFFICE EXPENSE	0
	THEFT & DAMAGE LOSS	0
	TELEPHONE	31,576
	MESSENGER SERVICE	0
	LAGACY SALARY	91,015
		444,658

LINE	SCHED REF	TOTAL
22	EMPLOYEE BENEFITS & PAYROLL TAXES	
	FICA TAXES XIX D	361,496
	UNEMPLOYMENT COMPENSATION XIX D	24,836
	WORKERS COMPENSATION INSURANC XIX D	209,362
	HOSPITALIZATION INSURANCE XIX D	254,750
	EMPLOYEE BENEFITS - OTHER XIX D	17,865
	EMPLOYEE PHYSICAL EXAMS XIX D	5,777
	INSURANCE - EXECUTIVE LIFE VI 21/XIX D	2,671
	PENSION/PROFIT SHARING PLANS XIX D	30,515
	CHICAGO HEAD TAX XIX D	
	PAYROLL TAXES - LEGACY	20,814
		928,086
23	INSERVICE TRAINING & EDUCATION	
	EDUCATION & SEMINARS	4,527
		4,527
24	TRAVEL & SEMINARS	
	EDUCATION & SEMINARS XIX G	0
	TRAVEL XIX G	0
		0
25	ADMIN. STAFF TRANSPORTATION	
	TRANSPORTATION - STAFF	11,557
		11,557
26	INSURANCE - PROP. LIAB & MALPRACTICE	
	GENERAL INSURANCE	2,510
		2,510
27	OTHER	
	BAD DEBTS VI 24	354,586
		354,586

GRAND TOTAL COLUMN 3 OTHER **4,268,079**

**PETERSON PARK HEALTH CR CTR
SCHEDULES
12/31/2014**

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

TOTAL FOOD PURCHASE	555,038
LESS SALES TAX	<u>(4,364)</u>
NET FOOD	550,674
TOTAL PATIENT CENSUS	62,708
TIMES 3 MEALS PER DAY	<u>3</u>
TOTAL PATIENT MEALS	188,124
ADD # EMPLOYEE MEALS/DAY	80
TIMES # DAYS	<u>365</u>
TOTAL EMPLOYEE MEALS	29,200
PATIENT MEALS	188,124
ADD EMPLOYEE MEALS	<u>29,200</u>
TOTAL MEALS/YEAR	217,324
NET FOOD	550,674
DIVIDE TOTAL MEALS/YEAR	<u>217,324</u>
COST PER MEAL	2.53
TIMES EMPLOYEE MEALS	<u>29,200</u>
EMPLOYEE MEAL RECLASSIFICATION	<u><u>73,876</u></u>

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	304,468	312,555			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			43,790	43,790		43,790	142,770	186,560			32
33	Real Estate Taxes							265,892	265,892			33
34	Rent-Facility & Grounds			1,043,722	1,043,722		1,043,722	(1,043,722)				34
35	Rent-Equipment & Vehicles			14,848	14,848		14,848	(8,439)	6,409			35
36	Other (specify):*							25,281	25,281			36
37	TOTAL Ownership			1,110,447	1,110,447		1,110,447	(313,750)	796,697			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		204,571	577,029	781,600		781,600		781,600			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			459,702	459,702		459,702		459,702			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		204,571	1,036,731	1,241,302		1,241,302		1,241,302			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	4,810,779	1,385,588	6,415,257	12,611,624		12,611,624	(1,992,477)	10,619,147			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	65,275	30		9
10	Interest and Other Investment Income	(409)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(4,364)	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	(295)	21		18
19	Entertainment	(12,670)	20		19
20	Contributions	(85,320)	20		20
21	Owner or Key-Man Insurance	(2,671)	22		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(354,586)	27		24
25	Fund Raising, Advertising and Promotional	(52,898)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(1,000)	20		28
29	Other-Attach Schedule	(40,646)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (489,584)		\$	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)	(1,502,893)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (1,502,893)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B)	\$ (1,992,477)		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 HEALTH CR CTR

ID# 0024463

Report Period Beginning: 01/01/2014

Ending: 12/31/2014

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	BANK CHARGES	\$ (1,054)	21	1
2	RELATED PARTY- ML GROUP	(18,000)	6	2
3	LIFELINE AMBULANCE	(3,905)	14	3
4	AUTO LEASE	(8,469)	35	4
5	NON ALLOWABLE TRANSPORTATION	(9,218)	25	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		(40,646)	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number PETERSON PARK HEALTH CR CTR# 0024463

Report Period Beginning:

01/01/2014

Ending:

12/31/2014

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	(4,364)	0	(2)	0	11	0	0	0	0	0	0	(4,355)	2
3	Housekeeping	0	0	870	0	0	0	0	0	0	0	0	870	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	1,733	0	0	0	0	0	0	0	0	1,733	5
6	Maintenance	(18,000)	0	2,019	0	68	0	(18,000)	0	0	0	0	(33,913)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(22,364)	0	4,620	0	79	0	(18,000)	0	0	0	0	(35,665)	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	(43,994)	0	0	0	0	0	0	(43,994)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	355	0	0	0	0	0	0	0	0	355	11
12	Social Services	0	0	0	0	4,087	0	0	0	0	0	0	4,087	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	(3,905)	0	0	0	0	0	0	0	0	0	0	(3,905)	14
15	Other (specify):*	0	0	0	0	162	0	0	0	0	0	0	162	15
16	TOTAL Health Care and Programs	(3,905)	0	355	0	(39,745)	0	0	0	0	0	0	(43,295)	16
	C. General Administration													
17	Administrative	0	0	(341,273)	0	6,811	0	0	0	(862,573)	0	0	(1,197,035)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	30,891	5,832	98	471	(4,878)	0	0	0	0	0	32,414	19
20	Fees, Subscriptions & Promotions	(151,888)	0	478	0	18	0	0	0	0	0	0	(151,392)	20
21	Clerical & General Office Expenses	(1,349)	0	(189,836)	0	1,781	0	0	0	0	0	0	(189,404)	21
22	Employee Benefits & Payroll Taxes	(2,671)	0	0	0	0	0	0	0	0	0	0	(2,671)	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	494	0	14	0	0	0	0	0	0	508	24
25	Other Admin. Staff Transportation	(9,218)	0	0	0	0	0	0	0	0	0	0	(9,218)	25
26	Insurance-Prop.Liab.Malpractice	0	225,852	829	0	0	0	0	0	0	0	0	226,681	26
27	Other (specify):*	(354,586)	0	34,268	0	514	0	0	0	10,154	0	0	(309,650)	27
28	TOTAL General Administration	(519,712)	256,743	(489,208)	98	9,609	(4,878)	0	0	(852,419)	0	0	(1,599,767)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(545,981)	256,743	(484,233)	98	(30,057)	(4,878)	(18,000)	0	(852,419)	0	0	(1,678,727)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number PETERSON PARK HEALTH CR CTR# 0024463

Report Period Beginning:

01/01/2014 Ending:

12/31/2014

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	65,275	233,829	2,205	3,159	0	0	0	0	0	0	0	304,468	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(409)	141,233	13	1,933	0	0	0	0	0	0	0	142,770	32
33	Real Estate Taxes	0	263,108	2,784	0	0	0	0	0	0	0	0	265,892	33
34	Rent-Facility & Grounds	0	(1,043,722)	9,970	(9,970)	0	0	0	0	0	0	0	(1,043,722)	34
35	Rent-Equipment & Vehicles	(8,469)	0	0	0	30	0	0	0	0	0	0	(8,439)	35
36	Other (specify):*	0	25,281	0	0	0	0	0	0	0	0	0	25,281	36
37	TOTAL Ownership	56,397	(380,271)	14,972	(4,878)	30	0	0	0	0	0	0	(313,750)	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
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(489,584)	(123,528)	(469,261)	(4,780)	(30,027)	(4,878)	(18,000)	0	(852,419)	0	0	(1,992,477)	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

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							3
4	V	19 PROF FEES		PETERSON PARK REALTY		30,891	30,891	4
5	V	26 INSURANCE - GENERAL		PETERSON PARK REALTY		225,852	225,852	5
6	V	30 DEPRECIATION		PETERSON PARK REALTY		233,829	233,829	6
7	V	32 AMORT LOAN COSTS		PETERSON PARK REALTY		7,719	7,719	7
8	V	32 INTEREST		PETERSON PARK REALTY		133,514	133,514	8
9	V	33 REAL ESTATE TAXES		PETERSON PARK REALTY		263,108	263,108	9
10	V	36 INSURANCE H.U.D. (MIP)		PETERSON PARK REALTY		25,281	25,281	10
11	V							11
12	V							12
13	V							13
14	Total		\$ 1,043,722			\$ 920,194	\$ * (123,528)	14

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

Facility Name & ID Number PETERSON PARK HEALTH CR CTR# 0024463Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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	\$ 366,443	LEGACY HEALTHCARE FINANCIAL SERVICES LLC		\$ (366,443)	15
16	V	21	OUTSIDE CLERICAL	319,000	LEGACY HEALTHCARE FINANCIAL SERVICES LLC		(319,000)	16
17	V	2	FOOD		LEGACY HEALTHCARE FINANCIAL SERVICES LLC	(2)	(2)	17
18	V	3	HOUSEKEEPING SALARIES		LEGACY HEALTHCARE FINANCIAL SERVICES LLC	777	777	18
19	V	3	HOUSEKEEPING		LEGACY HEALTHCARE FINANCIAL SERVICES LLC	93	93	19
20	V	5	UTILITIES		LEGACY HEALTHCARE FINANCIAL SERVICES LLC	1,733	1,733	20
21	V	6	GROUNDS & MAINTENANCE		LEGACY HEALTHCARE FINANCIAL SERVICES LLC	2,019	2,019	21
22	V	11	ACTIVITIES PROGRAM		LEGACY HEALTHCARE FINANCIAL SERVICES LLC	355	355	22
23	V	17	MANAGEMENT FEES		LEGACY HEALTHCARE FINANCIAL SERVICES LLC	25,170	25,170	23
24	V	19	PROFESSIONAL FEES		LEGACY HEALTHCARE FINANCIAL SERVICES LLC	5,832	5,832	24
25	V	20	FEES,SUBSCRIPTIONS		LEGACY HEALTHCARE FINANCIAL SERVICES LLC	478	478	25
26	V	21	CLERICAL & GENERAL WAGES		LEGACY HEALTHCARE FINANCIAL SERVICES LLC	121,164	121,164	26
27	V	21	CLERICAL & GENERAL		LEGACY HEALTHCARE FINANCIAL SERVICES LLC	8,000	8,000	27
28	V	24	SEMINARS		LEGACY HEALTHCARE FINANCIAL SERVICES LLC	494	494	28
29	V	26	INSURANCE		LEGACY HEALTHCARE FINANCIAL SERVICES LLC	829	829	29
30	V	27	EMPL BENEFITS-GEN ADMIN		LEGACY HEALTHCARE FINANCIAL SERVICES LLC	24,760	24,760	30
31	V	27	EMPL BENEFITS-OWNERS		LEGACY HEALTHCARE FINANCIAL SERVICES LLC	9,508	9,508	31
32	V	30	DEPRECIATION		LEGACY HEALTHCARE FINANCIAL SERVICES LLC	2,205	2,205	32
33	V	32	INTEREST		LEGACY HEALTHCARE FINANCIAL SERVICES LLC	13	13	33
34	V	33	REAL ESTATE TAXES		LEGACY HEALTHCARE FINANCIAL SERVICES LLC	2,784	2,784	34
35	V	34	RENT		LEGACY HEALTHCARE FINANCIAL SERVICES LLC	9,970	9,970	35
36	V							36
37	V							37
38	V							38
39	Total		\$ 685,443			\$ 216,182	\$ * (469,261)	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	\$ 9,970	LEGACY REAL PROPERTIES LLC		\$	(9,970)
16	V	19 PROFESSIONAL FEES		LEGACY REAL PROPERTIES LLC		98	98
17	V	30 DEPRECIATION		LEGACY REAL PROPERTIES LLC		3,159	3,159
18	V	32 INTEREST EXPENSE		LEGACY REAL PROPERTIES LLC		1,933	1,933
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		\$ 9,970			\$ 5,190	\$ * (4,780)

* 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	2 FOOD		PROGRESSIVE HEALTHCARE CONSULTING		11	11
17	V	6 BUILDING MAINT & SUPPLIES		PROGRESSIVE HEALTHCARE CONSULTING		68	68
18	V	10 NURSING SUPPLIES		PROGRESSIVE HEALTHCARE CONSULTING		5	5
19	V	10 NURSING SALARIES		PROGRESSIVE HEALTHCARE CONSULTING		4,001	4,001
20	V	12 CLERGY SALARY		PROGRESSIVE HEALTHCARE CONSULTING		167	167
21	V	12 ADMISSIONS SALARY		PROGRESSIVE HEALTHCARE CONSULTING		3,920	3,920
22	V	15 EMPL BENEFIT- NURSING		PROGRESSIVE HEALTHCARE CONSULTING		162	162
23	V	17 ADMIN SAL-NON OWNERS		PROGRESSIVE HEALTHCARE CONSULTING		6,811	6,811
24	V	19 PROFESSIONAL FEES		PROGRESSIVE HEALTHCARE CONSULTING		471	471
25	V	20 FEES, SUBSCRIPTIONS		PROGRESSIVE HEALTHCARE CONSULTING		18	18
26	V	21 CLERICAL & GEN OFFICE		PROGRESSIVE HEALTHCARE CONSULTING		1,781	1,781
27	V	24 SEMINARS		PROGRESSIVE HEALTHCARE CONSULTING		14	14
28	V	27 AUTO AND TRAVEL		PROGRESSIVE HEALTHCARE CONSULTING		514	514
29	V	35 EQUIPMENT RENTAL		PROGRESSIVE HEALTHCARE CONSULTING		30	30
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 48,000			\$ 17,973	\$ * (30,027)

* 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	19 PAYROLL DATA PROCESSING	\$ 23,229	PROPAY HR LLC		\$ 18,351	\$ (4,878)
16	V						
17	V						
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		\$ 23,229			\$ 18,351	\$ * (4,878)

* 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	6 ASSET MANAGEMENT FEE	\$ 18,000	ML GROUP DESIGN		\$	\$ (18,000)
16	V						
17	V						
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		\$ 18,000			\$ 0	\$ * (18,000)

* 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	6 PREVENTATIVE MAINTENANCE FE	\$ 6,782	REMED SERVICES		\$ 6,782	\$	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		\$ 6,782			\$ 6,782	\$ *	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 MANAGEMENT FEES	\$ 1,062,573	SHABAT & ASSOCIATES		\$	(1,062,573)
16	V	17 SALARY- RON SHABAT				200,000	200,000
17	V	27 PAYROLL TAXES				10,154	10,154
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		\$ 1,062,573			\$ 210,154	\$ * (852,419)

* 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 DON SALARIES	\$ 2,988	PROGRESSIVE HEALTHCARE CONSULTING		\$ 2,988	\$
16	V	10 CLINICAL NURSE	22,298	PROGRESSIVE HEALTHCARE CONSULTING		22,298	
17	V	10 MDS COORDINATOR	8,224	PROGRESSIVE HEALTHCARE CONSULTING		8,224	
18	V	10 E.H.R. IMPLEMENTATION	15,589	PROGRESSIVE HEALTHCARE CONSULTING		15,589	
19	V	10 CLERGY	3,199	PROGRESSIVE HEALTHCARE CONSULTING		3,199	
20	V	1 DIETARY AIDES	832	PROGRESSIVE HEALTHCARE CONSULTING		832	
21	V	17 ADMINISTRATOR	37,762	PROGRESSIVE HEALTHCARE CONSULTING		37,762	
22	V	17 ASSISTED ADMINISTRATOR	10,027	PROGRESSIVE HEALTHCARE CONSULTING		10,027	
23	V	21 ADMITTING	49,339	PROGRESSIVE HEALTHCARE CONSULTING		49,339	
24	V	21 PERSONNEL	7,127	LEGACY HEALTHCARE FINANCIAL SERVICES LLC		7,127	
25	V	21 A/R FIELD COORDINATOR	14,648	LEGACY HEALTHCARE FINANCIAL SERVICES LLC		14,648	
26	V	21 MANAGED CARE COORDINATOR	4,988	LEGACY HEALTHCARE FINANCIAL SERVICES LLC		4,988	
27	V	21 IN-HOUSE COUNSEL	9,101	LEGACY HEALTHCARE FINANCIAL SERVICES LLC		9,101	
28	V	21 PURCHASING DIRECTOR	4,926	LEGACY HEALTHCARE FINANCIAL SERVICES LLC		4,926	
29	V	21 CORP TRAINOR	886	LEGACY HEALTHCARE FINANCIAL SERVICES LLC		886	
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 191,934			\$ 191,934	\$ *

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

Facility Name & ID Number

PETERSON PARK HEALTH CR CTR

0024463

Report Period Beginning:

01/01/2014

Ending:

12/31/2014

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	CHAIM RAJCHENBACH	5.32	ASTORIA PLACE	CHICAGO	buffalo property holdings		BUILDING CO	1
2	MENACHEM SHABAT	9.04	BETHANY TERRACE	MORTON GROVE	legacy real properties		BUILDING CO	2
3	JACK RAJCHENBACH	9.57	CHALET LIVING & REHAB	CHICAGO	legacy healthcare fin services		home office/bookeep	3
4	RONALD SHABAT	69.15	ELMBROOK	ELMHURST	ml group design and dev		asset management	4
5	PPA, LTD.	5.32	THE GROVE OF EVANSTON,LLC	EVANSTON				5
6	AHUVA SHABAT	1.60	THE VILLA AT EVERGREEN	EVERGREEN PARK				6
7			THE GROVE OF FOX VALLEY	AURORA				7
8			THE GROVE OF LAGRANGE PARK	LAGRANGE PARK				8
9			THE GROVE AT THE LAKE	ZION				9
10			LAKEFRONT NURSING & REHAB CENTER	CHICAGO				10
11			the grove at lincoln park living and rehab	CHICAGO				11
12			AVANTARA LONG GROVE	LONG GROVE				12
13			THE GROVE NORTH LIVING AND REHAB	SKOKIE				13
14			THE GROVE OF NORTHBROOK	NORTHBROOK				14
15			WARREN BARR NORTH SHORE	HIGHLAND PARK				15
16			AVANTAR PARK RIDGE	PARK RIDGE				16
17			WARREN BARR SOUTH LOOP	CHICAGO				17
18			WARREN BARR	CHICAGO				18
19			AURORA SUPPORTIVE LIVING	AURORA				19
20			peterson park associates limited ptnship	CHICAGO				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 HEALTH CR CTR # 0024463 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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	69.15	NONE	35	100.00	SALARY	\$ 200,000	17-7	1
2								P/R TAXES	10,154	27-7	2
3											3
4	ALLOCATION FROM LEGACY HEALTHCARE FINANCIAL SERVICES:										4
5	CHAIM RAJCHENBACH	OWNER	Administrative	5.32	SEE ATTACHED	3.15	6.30	SALARY	12,585	17-7	5
6								P/R TAXES	4,754	27-7	6
7											7
8	MENACHEM SHABAT	OWNER	Administrative	9.04	SEE ATTACHED	3.15	6.30	SALARY	12,585	17-7	8
9								P/R TAXES	4,754	27-7	9
10											10
11											11
12											12
13								TOTAL	\$ 244,832		13

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

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

Facility Name & ID Number PETERSON PARK HEALTH CR CTR

0024463

Report Period Beginning:

01/01/2014

Ending: 2/31/2014

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 HEALTH CR CTR

0024463

Report Period Beginning:

01/01/2014

Ending: 2/31/2014

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	21	\$ (38)	\$	68,620	(2)	1
2	3	HOUSEKEEPING SALARIES	Bed Days Available	21	12,349	12,349	68,620	777	2
3	3	HOUSEKEEPING	Bed Days Available	21	1,477		68,620	93	3
4	5	UTILITIES	Bed Days Available	21	27,544		68,620	1,733	4
5	6	GROUNDS & MAINTENANCE	Bed Days Available	21	32,093		68,620	2,019	5
6	11	ACTIVITIES PROGRAM	Bed Days Available	21	5,642		68,620	355	6
7	17	MANAGEMENT FEES	Bed Days Available	21	400,000	400,000	68,620	25,170	7
8	19	PROFESSIONAL FEES	Bed Days Available	21	92,690		68,620	5,832	8
9	20	FEES,SUBSCRIPTIONS	Bed Days Available	21	7,596		68,620	478	9
10	21	CLERICAL & GENERAL WAGES	Bed Days Available	21	1,925,545	1,925,545	68,620	121,164	10
11	21	CLERICAL & GENERAL	Bed Days Available	21	127,135		68,620	8,000	11
12	24	SEMINARS	Bed Days Available	21	7,856		68,620	494	12
13	26	INSURANCE	Bed Days Available	21	13,167		68,620	829	13
14	27	EMPL BENEFITS-GEN ADMIN	Bed Days Available	21	393,489		68,620	24,760	14
15	27	EMPL BENEFITS-OWNERS	Bed Days Available	21	151,094		68,620	9,508	15
16	30	DEPRECIATION	Bed Days Available	21	35,040		68,620	2,205	16
17	32	INTEREST	Bed Days Available	21	199		68,620	13	17
18	33	REAL ESTATE TAXES	Bed Days Available	21	44,250		68,620	2,784	18
19	34	RENT	Bed Days Available	21	158,445		68,620	9,970	19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 3,435,573	\$ 2,337,894		\$ 216,182	25

Facility Name & ID Number PETERSON PARK HEALTH CR CTR

0024463

Report Period Beginning:

01/01/2014

Ending: 2/31/2014

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	19	PROFESSIONAL FEES	Bed Days Available	1,090,513	21	\$ 1,550	\$ 68,620	\$ 98	1
2	30	DEPRECIATION	Bed Days Available	1,090,513	21	50,196	68,620	3,159	2
3	32	INTEREST EXPENSE	Bed Days Available	1,090,513	21	30,719	68,620	1,933	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					\$ 82,465	\$	\$ 5,190	25

Facility Name & ID Number PETERSON PARK HEALTH CR CTR

0024463

Report Period Beginning:

01/01/2014

Ending: 2/31/2014

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	2	FOOD	Bed Days Available	21	\$ 149	\$	68,620	\$ 11	1
2	6	BUILDING MAINT & SUPPLIES	Bed Days Available	21	943		68,620	68	2
3	10	NURSING SUPPLIES	Bed Days Available	21	68		68,620	5	3
4	10	NURSING SALARIES	Bed Days Available	21	55,460	55,460	68,620	4,001	4
5	12	CLERGY SALARY	Bed Days Available	21	2,320	2,320	68,620	167	5
6	12	ADMISSIONS SALARY	Bed Days Available	21	54,336	54,336	68,620	3,920	6
7	15	EMPL BENEFIT- NURSING	Bed Days Available	21	2,247		68,620	162	7
8	17	ADMIN SAL-NON OWNERS	Bed Days Available	21	94,409	94,409	68,620	6,811	8
9	19	PROFESSIONAL FEES	Bed Days Available	21	6,532		68,620	471	9
10	20	FEES, SUBSCRIPTIONS	Bed Days Available	21	250		68,620	18	10
11	21	CLERICAL & GEN OFFICE	Bed Days Available	21	24,680		68,620	1,781	11
12	24	SEMINARS	Bed Days Available	21	199		68,620	14	12
13	27	AUTO AND TRAVEL	Bed Days Available	21	7,129		68,620	514	13
14	35	EQUIPMENT RENTAL	Bed Days Available	21	413		68,620	30	14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 249,135	\$ 206,525		\$ 17,973	25

Facility Name & ID Number PETERSON PARK HEALTH CR CTR

0024463

Report Period Beginning:

01/01/2014

Ending: 2/31/2014

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

PRO PAY HR LLC

Street Address

2201 W MAIN STREET

City / State / Zip Code

EVANSTON, ILL 60202

Phone Number

(847) 905-3268

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	19	PAYROLL DATA PROCESSING DIRECT	1	1	\$ 18,351	\$	1	\$ 18,351	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				\$ 18,351	\$		\$ 18,351	25

Facility Name & ID Number PETERSON PARK HEALTH CR CTR

0024463

Report Period Beginning:

01/01/2014

Ending: 2/31/2014

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 ML GROUP DESIGN
 Street Address 7040 N RIDGEWAY AVENUE
 City / State / Zip Code LINCOLNWOOD, ILL 60712
 Phone Number (773) 415-3071
 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	6	BUILDING SUPPLIES	DIRECT	1	1	\$	\$	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	TOTALS					\$	\$		\$

Facility Name & ID Number PETERSON PARK HEALTH CR CTR

0024463

Report Period Beginning:

01/01/2014

Ending: 2/31/2014

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 REMED
 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	6	PREVENTATIVE MAINT FEE	DIRECT	1	1	\$ 6,782	\$ 1	\$ 6,782	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					\$ 6,782	\$	\$ 6,782	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	CAPITAL ONE COMMBK		X	MORTGAGE	\$33,404.55	7/01/12	5,545,100	4,934,639	11/01/29	0.0265	133,514	3					
4												4					
5	LOAN COSTS		X	AMORTIZE OVER LIFE OF LOAN							7,719	5					
Working Capital																	
6	BANK FINANCIAL		X	LINE OF CREDIT							43,628	6					
7											162	7					
8	RELATED PARTY										1,946	8					
9	TOTAL Facility Related				\$33,404.55		\$ 5,545,100	\$ 4,934,639			\$ 186,969	9					
B. Non-Facility Related*																	
10												10					
11												11					
12												12					
13												13					
14	TOTAL Non-Facility Related						\$	\$			\$	14					
15	TOTALS (line 9+line14)						\$ 5,545,100	\$ 4,934,639			\$ 186,969	15					

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 25,281 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 2013 report.		\$	254,338		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.)		\$	261,507		2										
3. Under or (over) accrual (line 2 minus line 1).		\$	7,169		3										
4. Real Estate Tax accrual used for 2014 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	258,723		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.		\$	265,892		7										
Real Estate Tax History:															
Real Estate Tax Bill for Calendar Year:	2009	221,013	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 2013 \$</td> </tr> <tr> <td style="text-align: center;">14</td> <td>PLUS APPEAL COST FROM LINE 5 \$</td> </tr> <tr> <td style="text-align: center;">15</td> <td>LESS REFUND FROM LINE 6 \$</td> </tr> <tr> <td style="text-align: center;">16</td> <td>AMOUNT TO USE FOR RATE CALCULATION \$</td> </tr> </table>		FOR BHF USE ONLY		13	FROM R. E. TAX STATEMENT FOR 2013 \$	14	PLUS APPEAL COST FROM LINE 5 \$	15	LESS REFUND FROM LINE 6 \$	16	AMOUNT TO USE FOR RATE CALCULATION \$
FOR BHF USE ONLY															
13	FROM R. E. TAX STATEMENT FOR 2013 \$														
14	PLUS APPEAL COST FROM LINE 5 \$														
15	LESS REFUND FROM LINE 6 \$														
16	AMOUNT TO USE FOR RATE CALCULATION \$														
	2010	230,635	9												
	2011	233,727	10												
	2012	258,087	11												
	2013	261,507	12												
THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED ON ~ 101% OF THE PRIOR YEAR REAL ESTATE TAX BILL															
THE PAYMENT ON LINE 2 APPLIES TO THE 2013 TAX BILL.															

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.

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 2013 tax bills which were listed in Section A to this statement. Be sure to use the 2013 tax bill which is normally paid during 2014.

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>5,148</u>	2
3	TOTALS			\$ 288,219	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	\$ 137,394	35	\$ 72,824	\$ (64,570)	\$ 2,111,896	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	15,878	16
17	VARIOUS		1988	35,577		31	1,147	1,147	30,203	17
18	VARIOUS		1989	14,591		31	470	470	11,939	18
19	VARIOUS		1990	27,693		31	894	894	21,501	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	(684)	(684)	21,815	22
23	VARIOUS		1994	264,384		20	9,704	9,704	264,384	23
24	VARIOUS		1995	103,507		20	5,176	5,176	100,691	24
25	VARIOUS		1996	35,086		20	1,757	1,757	32,608	25
26	VARIOUS		1997	62,950		20	3,150	3,150	54,800	26
27	VARIOUS		1998	49,698		20	2,487	2,487	41,572	27
28	VARIOUS		1999	87,532		20	4,383	4,383	69,328	28
29	VARIOUS		2000	188,443		20	9,427	9,427	136,919	29
30	VARIOUS		2001	73,918		20	3,700	3,700	50,582	30
31	VARIOUS		2002	350,099		20	17,508	17,508	218,836	31
32	VARIOUS		2003	78,238		20	3,908	3,908	44,966	32
33	VARIOUS		2004	66,172		20	3,309	3,309	34,721	33
34	VARIOUS		2005	53,841		20	2,693	2,693	25,266	34
35	VARIOUS		2006	50,608		20	2,531	2,531	21,505	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

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	\$ 137,394		\$ 144,956	\$ 7,562	\$ 3,613,343	70

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

Facility Name & ID Number PETERSON PARK HEALTH CR CTR

0024463

Report Period Beginning:

01/01/2014

Ending:

12/31/2014

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	\$ 137,394		\$ 144,956	\$ 7,562	\$ 3,613,343	1
2	CONCRETE DOCK	2007	3,500		15	233	233	1,738	2
3	REHAB NURSING STATION	2007	11,394		20	570	570	4,275	3
4	RENOVATION 1ST FLOOR CORRIDOR AND LOBBY	2007	255,996		20	12,800	12,800	96,000	4
5	RENOVATION THERAPY REHAB ROOM	2007	12,744		20	637	637	4,778	5
6	SECURITY SYSTEM	2007	6,100		20	305	305	2,287	6
7	ROOF	2007	17,600		20	880	880	4,620	7
8	5 TON MULGIAGUA R-22 PACKGD ELECTRIC HIGH EFF	2007	32,940		20	1,647	1,647	12,353	8
9	CABLE WIRING	2007	12,500		20	625	625	4,687	9
10	NURSE CALL SYSTEM	2007	10,612		20	531	531	3,982	10
11	CIRCULATION OF HOT WATER LINES	2007	8,770		20	439	439	3,292	11
12	REAR ENTRANCE DOOR	2007	3,308		20	165	165	1,238	12
13	ELEVATOR REHAB 4 NEW NYLON PLATED GUILDE SHOES	2007	3,297		20	165	165	1,238	13
14	LANDSCAPING	2008	16,600		15	1,107	1,107	7,196	14
15	AWNING	2008	3,500		27.5	127	127	850	15
16	ELEVATOR REHAB	2008	5,500		27.5	200	200	1,338	16
17	ROOF	2008	4,000		27.5	145	145	970	17
18	COOPER PIPING	2008	2,860		27.5	104	104	696	18
19	CABLE WIRING	2008	3,850		27.5	140	140	936	19
20	A/C UNITS	2008	4,497		27.5	163	163	1,090	20
21	GATE VALVES	2008	2,800		27.5	102	102	682	21
22	NURSE CALL SYSTEM	2008	11,990		27.5	436	436	2,916	22
23	REPLACE HOT WATER & CIRCULATION LINES	2008	3,900		27.5	142	142	950	23
24	CABLE WIRING	2008	10,460		27.5	380	380	2,542	24
25	HOT WATER LINES	2008	7,500		27.5	273	273	1,826	25
26	A/C UNITS WITH SLEEVES	2008	3,951		27.5	144	144	963	26
27	BUILD IN WARDROBE CABINETS	2008	20,641		27.5	751	751	5,022	27
28	PAINTING	2009	39,906		20	1,995	1,995	13,966	28
29	SHADES, CORNICES & PANELS	2009	51,425		20	2,571	2,571	17,998	29
30	FLOORING & CARPETING	2009	5,410		20	271	271	1,896	30
31	WALLCOVERING, CORNICES & PANELS	2009	10,770		20	539	539	3,772	31
32	VINYL FLOORING	2009	5,481		20	274	274	1,918	32
33	SMOKE DETECTORS	2009	7,000		27.5	255	255	1,349	33
34	TOTAL (lines 1 thru 33)		\$ 5,035,466	\$ 137,394		\$ 174,072	\$ 36,678	\$ 3,822,707	34

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

Facility Name & ID Number PETERSON PARK HEALTH CR CTR

0024463

Report Period Beginning:

01/01/2014

Ending:

12/31/2014

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	\$ 137,394		\$ 174,072	\$ 36,678	\$ 3,822,707	1
2	GREASE TRAPS	2009	2,790		27.5	101	101	535	2
3	RECONDITION BOILER	2009	6,405		27.5	233	233	1,233	3
4	HOT WATER LINE	2009	5,180		27.5	188	188	995	4
5	WATER HEATER	2009	3,650		27.5	133	133	704	5
6	NURSE CALL SYSTEM	2009	21,666		27.5	788	788	4,170	6
7	HOT WATER & CIRCULATION LINE	2009	5,420		27.5	197	197	1,042	7
8	HOW WATER & CIRCULATION PIPES	2009	4,760		27.5	173	173	915	8
9	DRYWALL	2009	2,500		27.5	91	91	482	9
10	COPPER PIPING	2009	5,700		27.5	207	207	1,095	10
11	BATHROOM REMOD - LAVATORY, LIGHT FIX, WALL TOW	2009	12,407		27.5	451	451	2,387	11
12	CHAIR RAIL	2009	4,329		27.5	157	157	831	12
13	DRYWALL & DRAINS FOR 2 BATHTUBS	2009	5,600		27.5	204	204	1,079	13
14	PATIO	2009	10,390		15	693	693	3,725	14
15									15
16									16
17									17
18	DRYWALL METAL STUDS TIME & CONVERT TUB 2 SHOWI	2010	4,450		20	223	223	1,003	18
19	ROOM SIGNS	2010	12,108		20	605	605	2,723	19
20	CLINICAL SINKS	2010	7,121		20	356	356	1,602	20
21	PLUMBING IN UTILITY ROOM	2010	9,651		20	483	483	2,173	21
22	SIGN	2010	13,700		15	913	913	4,109	22
23	NURSES STATION - PANELS, BOARDS, GRANITE TOPS	2010	30,280		20	1,514	1,514	6,813	23
24	REHAB BATHROOM - ARCHITECT FEES	2010	4,170		20	209	209	940	24
25	REHAB BATHROOM - FAUCETS, LIGHTING, FLOORS	2010	32,452		20	1,623	1,623	7,303	25
26	CORRIDOR & DAY ROOM RENOV - COVE BASE, WINDOWS	2010	172,082		20	8,604	8,604	38,718	26
27	SOILDED UTILITY ROOM RENOVATION - CABINETS, SINK	2010	23,598		20	1,180	1,180	5,310	27
28	REHAB BATHROOMS - WALLS, LIGHTING, FLOORS	2010	77,780		20	3,889	3,889	17,501	28
29	CORRIDOR RENOVATION - WALLS, CHAIR RAILS, FLOOR	2010	172,732		20	8,637	8,637	38,866	29
30	TILING & WALLCOVERING FOR FOYER	2010	3,549		20	177	177	797	30
31	GENERATOR REPAIR	2010	2,526		20	126	126	567	31
32	THRU THE WALL HEATING & A/C UNITS	2010	5,626		20	281	281	1,265	32
33	SINKS & FAUCETS	2010	3,270		20	164	164	738	33
34	TOTAL (lines 1 thru 33)		\$ 5,701,358	\$ 137,394		\$ 206,672	\$ 69,278	\$ 3,972,328	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	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	\$ 137,394		\$ 206,672	\$ 69,278	\$ 3,972,328	1
2	TILING, PAINTING & REMODEL SOCIAL ROOM HALL OFF	2010	15,730		20	787	787	3,541	2
3	DRYWALL	2010	3,920		20	196	196	882	3
4	CHANGE LOCKS	2010	4,481		20	224	224	1,008	4
5	REMODEL PUBLIC BATHROOMS FLOOR WALL TOILET LI	2010	7,503		20	375	375	1,688	5
6	SHUT OFF VALVE & ACCESS PANELS IN SOILED UTLY RM	2010	3,994		20	200	200	900	6
7	REPLACE DRYWALL & STUDS IN BATHROOM	2010	2,930		20	147	147	661	7
8	REPLACE EXISTING TILE & BASEBOARDS & PAINT WALL	2010	9,990		20	499	499	2,246	8
9	REPLACE DRYWALL & STUDS & PAINTING	2010	7,918		20	396	396	1,782	9
10	REBUILT EJECTOR PUMP	2010	5,400		20	270	270	1,215	10
11	BATHROOM RESTORATION - WALLS & DRAINS	2010	9,350		20	468	468	2,106	11
12	RADIATOR HEATING SYSTEM	2010	9,590		20	480	480	2,160	12
13	HANDRAILS, BUMPERS, DOOR KNOBS	2010	4,350		20	218	218	981	13
14	TILING & BASEBOARDS, WALLS, CEILINGS, PAINT	2010	12,995		20	650	650	2,925	14
15	KITCHEN & EXHAUST FAN DUCTS, ELECTRICAL	2010	3,522		20	176	176	792	15
16	PAINTING & SINK IN MED ROOM	2010	6,470		20	324	324	1,458	16
17	DRYWALL, TILING, RAISING NURSE CALL SWITCHES	2010	4,050		20	203	203	913	17
18	PUMP REPAIRS/PUMP SEAL KIT	2010	2,642		20	132	132	594	18
19	ROOF - DRAINAGE	2010	2,600		20	130	130	585	19
20	DRAIN WATER LINE	2010	2,800		20	140	140	930	20
21	GLASS WALL/DOOR	2010	14,800		20	740	740	3,330	21
22	EMERGENCY/EXIT DOORS/DOOR OPENER	2010	4,200		20	210	210	945	22
23	ELECTRIAL & LIGHTING	2010	7,720		20	386	386	1,737	23
24	SIX WINDOWS	2010	3,000		20	150	150	675	24
25	HOT WATER TANK	2010	14,680		20	734	734	3,303	25
26	BEAUTY MIRROR INSTALLATION	2010	2,500		20	125	125	563	26
27	SEC 754 BASIS ADJ			8,087			(8,087)		27
28	ARCHITECT FEES	2011	6,000		27.5	218	218	782	28
29	CUSTOM CABINETS BUILD IT SECURED TO WALL	2011	2,800		27.5	102	102	366	29
30	SEWER PUMP MOTOR	2011	2,910		27.5	106	106	380	30
31	ARCHITECT FEES	2011	6,474		27.5	235	235	842	31
32	BOILERS	2011	63,550		27.5	2,311	2,311	8,280	32
33	DOORS WINDOWS & THERMOBRAKE METAL	2011	16,100		27.5	585	585	1,804	33
34	TOTAL (lines 1 thru 33)		\$ 5,966,327	\$ 145,481		\$ 218,589	\$ 73,108	\$ 4,022,702	34

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

Facility Name & ID Number PETERSON PARK HEALTH CR CTR

0024463

Report Period Beginning:

01/01/2014

Ending:

12/31/2014

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 12D, Carried Forward		\$ 5,966,327	\$ 145,481		\$ 218,589	\$ 73,108	\$ 4,022,702	1
2	MILLWORK & TRIM	2011	2,600		27.5	94	94	242	2
3	ELECTRIAL WORK IN BOILER/ELECTRICAL ROOM	2011	7,800		27.5	284	284	734	3
4	SPRINKLER SYSTEM CONNECTION	2011	3,900		27.5	142	142	366	4
5	INSTALL 2 NEW DEDICATED CIRCUITS NEW WASH/DRYR	2011	2,800		27.5	102	102	264	5
6	HIGH EFFICENCY CONDENSER	2011	4,250		27.5	154	154	398	6
7	REPLACE KITCHEN TILE	2011	4,230		27.5	154	154	346	7
8	REPLACE KITCHEN TILE	2011	3,865		27.5	140	140	317	8
9	HOT WATER BOILER REPAIRS IN BASEMENT	2011	7,250		27.5	264	264	594	9
10	DRAIN LINE REPLACEMENT	2011	2,700		27.5	98	98	220	10
11	SECURITY KEYPAD & WIRING FOR ELEVATOR	2011	5,950		27.5	216	216	486	11
12	REPLACE KITCHEN TILE	2011	3,975		27.5	145	145	326	12
13	CONCRETE WORK	2011	19,140		15	1,276	1,276	3,828	13
14	CANOPYS	2011	14,890		15	993	993	2,980	14
15	LANDSCAPE IRRIGATION SYSTEM	2011	11,880		15	792	792	2,376	15
16	PLANT INSTALLATION	2011	19,030		15	1,269	1,269	3,808	16
17	CORNICES, BLINDS, SHEERS	2011	10,058		5	2,012	2,012	6,036	17
18	EJECTOR PUMP	2012	7,190		27.5	261	261	413	18
19	LOCKERS	2012	4,058		27.5	147	147	233	19
20	ELECTRICAL CIRCUIT	2012	3,225		27.5	117	117	185	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	330	22
23	FIRE SPRINKLER	2012	3,990		27.5	145	145	229	23
24	window sill replacement on all windows on 1st & 2nd floor	2012	6,104		27.5	222	222	352	24
25	REPLACE METAL STUDS & DRYWALL IN STORAGE ROOM	2012	2,630		27.5	96	96	152	25
26	ELECTRIC WORK IN KITCHEN AREA	2012	2,970		27.5	108	108	170	26
27	REPLACED CRACKED DRAIN LINE	2012	2,580		27.5	94	94	148	27
28	HOT WATER BOILER	2012	84,380		27.5	3,068	3,068	4,858	28
29	REPLACED FASCIA GUTTERS,GRAVEL STOPPERS & ROOI	2012	17,900		27.5	651	651	1,031	29
30	TILE, NEW BASE LINER & CONCRETE BASE IN SHOWER	2012	6,320		27.5	230	230	364	30
31	NEW FIRE PANEL	2012	21,600		27.5	784	784	1,242	31
32	SCALD GUARD FOR SHOWERS	2012	6,663		27.5	242	242	384	32
33	ROOF-PATCH OPEN SEAMS, DRAINS AND FLESHING	2012	5,140			187	187	297	33
34	TOTAL (lines 1 thru 33)		\$ 6,271,115	\$ 145,481		\$ 233,284	\$ 87,803	\$ 4,056,411	34

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

Facility Name & ID Number PETERSON PARK HEALTH CR CTR

0024463

Report Period Beginning:

01/01/2014

Ending:

12/31/2014

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	\$ 145,481		\$ 233,284	\$ 87,803	\$ 4,056,411	1
2	shower remodeling-new base liner,concrete base,tile install	2012	3,980		27.5	148	148	232	2
3	ELECTRIC WORK IN BOILER ROOM	2012	4,130		27.5	150	150	238	3
4	WALK IN FREEZER	2012	4,636		27.5	168	168	266	4
5	COMPRESSOR	2012	2,800		27.5	102	102	162	5
6	HORIZONTAL RAILING BARS FOR STAIRWAYS	2012	6,900		27.5	251	251	397	6
7	BOILER EXHAUST LINES	2012	7,200		27.5	262	262	414	7
8	GREASE TRAP	2012	4,200		27.5	153	153	243	8
9	TV OUTLETS	2012	11,445		27.5	416	416	658	9
10	DRYWALL, PATCH & SAND	2012	2,986		27.5	108	108	172	10
11	NEW PARKING LOT	2012	24,390		15	1,626	1,626	3,252	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	3,990	3,990	6,151	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	396	396	611	17
18	RECEPTACLES IN VARIOUS LOCATIONS ON 1ST FLOOR	2013	7,034		27.5	256	256	394	18
19	VENTILATION SYSTEM	2013	2,641		27.5	96	96	132	19
20	RAILING BARS FOR EXISTING BALCONY	2013	6,650		27.5	242	242	333	20
21	KITCHEN DRAIN PIPING	2013	2,834		27.5	103	103	141	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	266	266	366	24
25	CORNICES, BLINDS AND SHADES	2013	3,819		5	611	611	993	25
26	REPLACE, PATCH, TAPE & PRIME DRYWALL, PAINT								26
27	WOODWORK, HANG WALLPAPERS IN THE ENTIRE FRONT								27
28	VESTIBULE. PAINT CEILING. METAL STUDS REPLACED	2014	2,980		5	298	298	298	28
29	MDS ROOM CEILING REPAIR, ROOM 227 WALL REPAIR,								29
30	ROOM 125 DRYWALL REPLACEMENT, ROOM 123								30
31	REPAIR WALLS AND CEILING, PAINTING; ROOM 125								31
32	REPAIR WALLS AND CEILING, PAINTING; ROOM 135								32
33	REPAIR WALLS AND CEILING, PAINTING,;ROOM 123								33
34	TOTAL (lines 1 thru 33)		\$ 6,497,684	\$ 145,481		\$ 242,926	\$ 97,445	\$ 4,071,864	34

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

Facility Name & ID Number PETERSON PARK HEALTH CR CTR

0024463

Report Period Beginning:

01/01/2014 Ending:

12/31/2014

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 12F, Carried Forward		\$ 6,497,684	\$ 145,481		\$ 242,926	\$ 97,445	\$ 4,071,864	1
2	BATHROOM- REPAIR WALLS AND CEILING, PAINTING;								2
3	ROOM 135 BATHROOM- REPAIR WALLS AND CEILING,								3
4	PAINTING; 1ST FLOOR MEN TOP ROOM- WALLS AND								4
5	CEILING REPAIR AND PAINT; 1ST FLOOR MEN TOP								5
6	ROOM BATHROOM- WALLS AND CEILING REPAIR								6
7	AND PAINT; 1ST FLOOR WOMEN TOP ROOM- WALLS								7
8	AND CEILING REPAIR AND PAINT; 1ST FLOOR								8
9	WOMEN TOP ROOM BATHROOM- WALLS AND CEILING								9
10	REPAIR AND PAINT; ROOM 122- WALLS AND CEILING								10
11	REPAIR AND PAINT; ROOM 122- BATHROOM CEILING								11
12	AND WALLS REPAIR; ROOM 122- BATHROOM SOFFIT								12
13	DRYWALL REPLACEMENT; FRPMT PF THE BUILDING-								13
14	ONE BRICK JOINT (FULL BUILDING HEIGHT) RE-								14
15	CAULKING	2014	13,730		5	1,373	1,373	1,373	15
16	REPAIR WALLS, CEILING, AND PAINTING IN ROOMS 131								16
17	AND 133; REPAIR WALLS, CEILING AND PAINTING IN								17
18	BATHROOM 131/133	2014	3,200		5	320	320	320	18
19	1 SOUTH FEMALE AND 2 SOUTH FEMALE- PAINT TUB								19
20	ROOM; 2 SOUTH MALE AND 2 NORTH MALE- PAINT								20
21	TUB ROOM	2014	7,600		5	760	760	760	21
22	2 NOTH MALE, 1 SOUTH MALE AND 2 NORTH FEMALE								22
23	TUB ROOMS EXTRAS; REPLACE SOME DRYWALL AND								23
24	METAL STUDS; PATCH AND PAINT	2014	2,650		5	265	265	265	24
25	1 SOUTH MALE AND 2 NORTH FEMALE- PAINT TUB ROOM	2014	3,800		5	380	380	380	25
26	CARPET TILE AND COVE BASE IN CONFERENCE ROOM								26
27	AND LOBBY	2014	3,393		5	339	339	339	27
28	TUCKPOINTING CHIMNEY & AROUND BUILDING	2014	2,800		27.5	30	30	30	28
29	ELECTRICAL SERVICE REPLACEMENT AND GENERATOR	2014	218,648		27.5	2,319	2,319	2,319	29
30	INSTALLATION								30
31	DOOR	2014	4,730		27.5	50	50	50	31
32	CABLES & CONDUITS	2014	2,833		27.5	30	30	30	32
33	GREASE TRAP GASKETS	2014	2,700		27.5	29	29	29	33
34	TOTAL (lines 1 thru 33)		\$ 6,763,768	\$ 145,481		\$ 248,821	\$ 103,340	\$ 4,077,759	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 12G, Carried Forward		\$ 6,763,768	\$ 145,481		\$ 248,821	\$ 103,340	\$ 4,077,759	1
2	WINDOW WELL COVERS	2014	3,900		27.5	41	41	41	2
3	AWNINGS	2014	4,500		27.5	48	48	48	3
4	ELECTRICAL WORK ON THE SECOND FLOOR SOUTH SIDE	2014	3,000		27.5	32	32	32	4
5	OF BUILDING - INSTALLED 50 PERMANENT 4 PLUG WALL								5
6	OUTLETS								6
7	1 SOUTH FEMALE TUB ROOM - REPLACING FLOOR VCT,	2014	3,610		27.5	38	38	38	7
8	INCLUDING REPAIRING & LEVELING OUT THE CONCRETE								8
9	FLOOR								9
10	2 NORTH FEMALE TUB ROOM - REPLACE TILE &	2014	2,650		27.5	28	28	28	10
11	BASEBOARDS & SCRAPING & TAPING CEILING								11
12	REPLACE FAILED FIRE DAMPER ACTUATORS	2014	3,498		27.5	37	37	37	12
13	FRONT CANOPY LOWER ROOF	2014	3,700		27.5	39	39	39	13
14	DOUBLE DOORS	2014	4,730		27.5	50	50	50	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)		\$ 6,793,356	\$ 145,481		\$ 249,134	\$ 103,653	\$ 4,078,072	34

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

Facility Name & ID Number PETERSON PARK HEALTH CR CTR

0024463

Report Period Beginning:

01/01/2014

Ending:

12/31/2014

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 12H, Carried Forward		\$ 6,793,356	\$ 145,481		\$ 249,134	\$ 103,653	\$ 4,078,072	1
2									2
3	RELATED PARTY INFORMATION								3
4	BUILDINGS:								4
5	ALLOCATED FROM LEGACY RP	2009	39,885	1,330	30	1,330			5
6									6
7									7
8									8
9	LEASED HOLD IMPROVEMENTS:								9
10	ALLOCATED FROM LEGACY RP (SEE ATTACHED)	2009	22,650	566	20	1,133	567		10
11	ALLOCATED FROM LEGACY RP (SEE ATTACHED)	2010	6,888	224	20	276	52		11
12	ALLOCATED FROM LEGACY RP (SEE ATTACHED)	2011	9,790		20	489	489		12
13									13
14									14
15									15
16									16
17									17
18	ALLOCATED FROM LEGACY HEALTHCARE FINANCIAL-	2012	1,794	125	20	90	(35)		18
19	CARPETING INSTALLATION AND FLOOR PREP, CUBICLES								19
20	WITH OVERHEAD STORAGE CABINETS AND FILE								20
21	CABINETS, CARPETIN INSTALLATION, OFFICE BUILD-								21
22	OUT-WALLS, INSULATION, ELECTRICAL, DOORS,								22
23	BASEBOARDS, LIGHTS, WINDOWS, PAINT, SECURITY								23
24	SYSTEM								24
25	ALLOCATED FROM LEGACY HEALTHCARE FINANCIAL-	2013	5,739	398	20	287	(111)		25
26	BUILDING SUPPLIES FOR 2013 IMPROVEMENTS, PHONE								26
27	SYSTEM & WIRING, BUILT IN SHELVING & DROP								27
28	CEILINGS								28
29									29
30	ALLOCATE FROM LEGACY HEALTHCARE FINANCIAL-								30
31	LIGHT FIXTURES AND ELECTRICAL WIRING,								31
32	PRINTER RECEPTACLES	2014	560	39	20	28	(11)		32
33									33
34	TOTAL (lines 1 thru 33)		\$ 6,880,662	\$ 148,163		\$ 252,767	\$ 104,604	\$ 4,078,072	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	\$ 507,856	\$ 13,136	\$ 50,164	\$ 37,028	10 YRS	\$ 245,471	71
72	Current Year Purchases	138,831	83,299	6,942	(76,357)	10 YRS	6,942	72
73	Fully Depreciated Assets	1,207,500					1,207,500	73
74	RELATED PARTY		2,682	2,682				74
75	TOTALS	\$ 1,854,187	\$ 99,117	\$ 59,788	\$ (39,329)		\$ 1,459,913	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)	\$ 9,023,068	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 247,280	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 312,555	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 65,275	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 5,537,985	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:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			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. _____ /2015 \$ _____

13. _____ /2016 \$ _____

14. _____ /2017 \$ _____

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized _____
by the length of the lease _____.

9. Option to Buy: YES NO Terms: _____ *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? YES NO

16. Rental Amount for movable equipment: \$ 6,379 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			\$	\$	17
18					18
19				8,469	19
20					20
21	TOTAL		\$	\$ 8,469	21

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

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

Facility Name & ID Number PETERSON PARK HEALTH CR CTR # 0024463 Report Period Beginning: 01/01/2014 Ending: 12/31/2014
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			Total
		1	2	3	
		Drop-outs	Completed	Contract	
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	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	\$		\$	222,073	\$		\$	222,073	1
2	Licensed Speech and Language Development Therapist	39-3	hrs				128,518				128,518	2
3	Licensed Recreational Therapist		hrs									3
4	Licensed Physical Therapist	39-3	hrs				226,438				226,438	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					204,571			204,571	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			\$		\$	577,029	\$	204,571	\$	781,600	14

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

Facility Name & ID Number **PETERSON PARK HEALTH CR CTR**# **0024463**Report Period Beginning: **01/01/2014**

Ending:

12/31/2014**XV. BALANCE SHEET - Unrestricted Operating Fund.**As of **12/31/2014**

(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	\$ 101,196	\$ 289,973	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (600,000))	2,727,952	2,727,952	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	52,743	237,701	6
7	Other Prepaid Expenses	120,585	603,511	7
8	Accounts Receivable (owners or related parties)	905,501	905,501	8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 3,907,977	\$ 4,764,638	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		4,102,745	15
16	Equipment, at Historical Cost		1,854,187	16
17	Accumulated Depreciation (book methods)		(5,684,565)	17
18	Deferred Charges		114,143	18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds		4,800	21
22	Other Long-Term Assets (specify):	96,373	96,373	22
23	Other(specify): Due from pp realty	3,081,458		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 3,177,831	\$ 3,139,017	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 7,085,808	\$ 7,903,655	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 1,524,986	\$ 1,547,957	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	2,107,949	2,381,340	29
30	Accrued Salaries Payable	748,001	748,001	30
31	Accrued Taxes Payable (excluding real estate taxes)	27,804	27,804	31
32	Accrued Real Estate Taxes(Sch.IX-B)		258,723	32
33	Accrued Interest Payable		10,897	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Accrued Management Fees	71,382	71,382	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 4,480,122	\$ 5,046,104	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		4,661,248	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)	\$	\$ 4,661,248	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 4,480,122	\$ 9,707,352	46
47	TOTAL EQUITY(page 18, line 24)	\$ 2,605,686	\$ (1,803,697)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 7,085,808	\$ 7,903,655	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 3,128,450	1
2	Restatements (describe):		2
3	POST 2013 CLOSING ENTRY- BAD DEBTS INCREASE	(40,211)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 3,088,239	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(82,553)	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	(400,000)	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)	\$ (482,553)	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)	\$ 2,605,686	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	\$ 12,451,159	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 12,451,159	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***	409	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 409	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)	\$ 12,451,568	30

		2	
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	1,990,851	31
32	Health Care	4,035,472	32
33	General Administration	4,233,552	33
B. Capital Expense			
34	Ownership	1,110,447	34
C. Ancillary Expense			
35	Special Cost Centers	781,600	35
36	Provider Participation Fee	459,702	36
D. Other Expenses (specify):			
37	OUT-OF-PERIOD EXPENSES	(89,361)	37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 12,522,263	40
41	Income before Income Taxes (line 30 minus line 40)**	(70,695)	41
42	Income Taxes	(11,858)	42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (82,553)	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 8,455,457	44
45	Private Pay - Net Inpatient Revenue	661,644	45
46	Medicare - Net Inpatient Revenue	2,875,807	46
47	Other-(specify) HOSPICE/INSURANCE/ETC	221,274	47
48	Other-(specify) INSURANCE	228,250	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 12,442,432	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 HEALTH CR CTR**

0024463

Report Period Beginning: **01/01/2014**

Ending:

12/31/2014

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	1,977	2,089	\$ 136,643	\$ 65.41	1
2	Assistant Director of Nursing	1,899	2,092	64,080	30.63	2
3	Registered Nurses	38,035	44,320	1,361,831	30.73	3
4	Licensed Practical Nurses	4,384	4,959	122,163	24.63	4
5	CNAs & Orderlies	95,188	103,238	1,128,035	10.93	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	8,116	9,265	161,629	17.45	8
9	Activity Director	1,880	2,089	29,552	14.15	9
10	Activity Assistants	10,195	11,722	138,722	11.83	10
11	Social Service Workers	11,611	13,322	172,542	12.95	11
12	Dietician					12
13	Food Service Supervisor	1,991	2,240	44,746	19.98	13
14	Head Cook					14
15	Cook Helpers/Assistants	20,964	23,080	292,627	12.68	15
16	Dishwashers					16
17	Maintenance Workers	3,913	4,286	67,935	15.85	17
18	Housekeepers	17,364	19,002	202,581	10.66	18
19	Laundry	12,149	13,295	141,741	10.66	19
20	Administrator	1,843	2,084	112,019	53.75	20
21	Assistant Administrator	2,874	3,072	91,519	29.79	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	8,638	9,899	142,706	14.42	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	1,840	2,089	41,174	19.71	31
32	Other Health C: Ward Clerk, MDS	8,955	10,138	190,012	18.74	32
33	Other(specify) <u>ADMITTING</u>	5,905	6,627	168,522	25.43	33
34	TOTAL (lines 1 - 33)	259,721	288,908	\$ 4,810,779 *	\$ 16.65	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	monthly fee	\$ 14,189	1-3	35
36	Medical Director	42	8,475	9-3	36
37	Medical Records Consultant	monthly fee	2,400	10-3	37
38	Nurse Consultant		0	10-3	38
39	Pharmacist Consultant	monthly fee	14,664	10-3	39
40	Physical Therapy Consultant		0	10a-3	40
41	Occupational Therapy Consultant		0	10a-3	41
42	Respiratory Therapy Consultant	15	1,745	10a-3	42
43	Speech Therapy Consultant		0	10a-3	43
44	Activity Consultant	monthly fee	6,000	11-3	44
45	Social Service Consultant	monthly fee	8,870	12-3	45
46	Other(specify) <u>REHABILITATION</u>	monthly fee	238	10-10a	46
47	<u>Nursing Program Consultant</u>	monthly fee	70,568	10-3	47
48	<u>Nursing</u>	monthly fee	24,000	10-3	48
49	TOTAL (lines 35 - 48)	57	\$ 151,149		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-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 HEALTH CR CTR

0024463

Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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 \$12,464
- (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. \$ 2,540 Line 10-2
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? NO
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? _____ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 459,702
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. \$ 73,876 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) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. YES
Attach invoices and a summary of services for all architect and appraisal fees.