

		FOR BHF USE					

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2011
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2011)

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

I. IDPH License ID Number: <u>0024463</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER																							
Facility Name: <u>PETERSON PARK HEALTH CARE CENTER</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/2011</u> to <u>12/31/2011</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge. Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.																							
Address: <u>6141 N. PULASKI</u> <u>CHICAGO</u> <u>60646</u>																									
Number City Zip Code																									
County: <u>COOK</u>																									
Telephone Number: <u>(773) 478-2000</u> Fax # <u>(773) 478-8408</u>																									
HFS ID Number: _____		<table><tr><td rowspan="4">Officer or Administrator of Provider</td><td>(Signed) _____</td></tr><tr><td>(Type or Print Name) <u>RONALD SHABAT</u></td></tr><tr><td>(Title) <u>PARTNER</u></td></tr><tr><td>(Signed) (SEE ATTACHED ACCOUNTANTS' REPORT)</td></tr><tr><td rowspan="4">Paid Preparer</td><td>(Date) _____</td></tr><tr><td>(Print Name <u>BOB KAGDA</u> and Title) <u>VICE PRESIDENT</u></td></tr><tr><td>(Firm Name <u>KRUPNICK, BOKOR, KAGDA & BROOKS, LTD</u> & Address) <u>3750 W DEVON, LINCOLNWOOD, IL 60712-1124</u></td></tr><tr><td>(Telephone) <u>(847) 675-3585</u> Fax # <u>(847) 675-5777</u></td></tr></table> MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630		Officer or Administrator of Provider	(Signed) _____	(Type or Print Name) <u>RONALD SHABAT</u>	(Title) <u>PARTNER</u>	(Signed) (SEE ATTACHED ACCOUNTANTS' REPORT)	Paid Preparer	(Date) _____	(Print Name <u>BOB KAGDA</u> and Title) <u>VICE PRESIDENT</u>	(Firm Name <u>KRUPNICK, BOKOR, KAGDA & BROOKS, LTD</u> & Address) <u>3750 W DEVON, LINCOLNWOOD, IL 60712-1124</u>	(Telephone) <u>(847) 675-3585</u> Fax # <u>(847) 675-5777</u>												
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	(Telephone) <u>(847) 675-3585</u> Fax # <u>(847) 675-5777</u>																								
Date of Initial License for Current Owners: <u>01/01/78</u>																									
Type of Ownership:																									
<table><tr><td>☐ VOLUNTARY,NON-PROFIT</td><td>☒ PROPRIETARY</td><td>☐ GOVERNMENTAL</td></tr><tr><td>☐ Charitable Corp.</td><td>☐ Individual</td><td>☐ State</td></tr><tr><td>☐ Trust</td><td>☒ Partnership</td><td>☐ County</td></tr><tr><td>IRS Exemption Code _____</td><td>☐ Corporation</td><td>☐ Other _____</td></tr><tr><td></td><td>☐ "Sub-S" Corp.</td><td></td></tr><tr><td></td><td>☐ Limited Liability Co.</td><td></td></tr><tr><td></td><td>☐ Trust</td><td></td></tr><tr><td></td><td>☐ Other _____</td><td></td></tr></table>		☐ VOLUNTARY,NON-PROFIT	☒ PROPRIETARY	☐ GOVERNMENTAL	☐ Charitable Corp.	☐ Individual	☐ State	☐ Trust	☒ Partnership	☐ County	IRS Exemption Code _____	☐ Corporation	☐ Other _____		☐ "Sub-S" Corp.			☐ Limited Liability Co.			☐ Trust			☐ Other _____	
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	☐ Trust																								
	☐ Other _____																								
In the event there are further questions about this report, please contact:																									
Name: <u>BOB KAGDA</u> Telephone Number: <u>(847) 675-3585</u>																									
Email Address: _____																									

Facility Name & ID Number PETERSON PARK HEALTH CARE CENTER

0024463 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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	<u>93</u>	Skilled (SNF)	<u>93</u>	<u>33,945</u>	1
2		Skilled Pediatric (SNF/PED)			2
3	<u>95</u>	Intermediate (ICF)	<u>95</u>	<u>34,675</u>	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>188</u>	TOTALS	<u>188</u>	<u>68,620</u>	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	<u>2,469</u>	<u>801</u>	<u>9,405</u>	<u>12,675</u>	8
9	SNF/PED					9
10	ICF	<u>49,170</u>	<u>3,755</u>	<u>195</u>	<u>53,120</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>51,639</u>	<u>4,556</u>	<u>9,600</u>	<u>65,795</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 95.88%

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 92 and days of care provided 8,710

Medicare Intermediary NATIONAL GOVERNMENT SERVICES

IV. ACCOUNTING BASIS

ACCRAUAL ☒ MODIFIED CASH* ☐ CASH* ☐

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

Tax Year: 12/31/2011 Fiscal Year: 12/31/2011

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

Facility Name & ID Number PETERSON PARK HEALTH CARE CENTI # 0024463 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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	434,520	49,956	28,109	512,585		512,585		512,585			1
2	Food Purchase		498,151		498,151	(63,948)	434,203	(2,551)	431,652			2
3	Housekeeping	234,981	58,314		293,295		293,295	1,089	294,384			3
4	Laundry	105,027	18,904	780	124,711		124,711		124,711			4
5	Heat and Other Utilities			191,219	191,219		191,219	2,252	193,471			5
6	Maintenance	69,257	79,631	98,632	247,520		247,520	5,241	252,761			6
7	Other (specify):*			16,235	16,235		16,235		16,235			7
8	TOTAL General Services	843,785	704,956	334,975	1,883,716	(63,948)	1,819,768	6,031	1,825,799			8
	B. Health Care and Programs											
9	Medical Director			31,000	31,000		31,000		31,000			9
10	Nursing and Medical Records	2,860,078	270,587	16,656	3,147,321		3,147,321	(6,858)	3,140,463			10
10a	Therapy	175,305		70,840	246,145		246,145		246,145			10a
11	Activities	157,635	25,891	5,880	189,406		189,406		189,406			11
12	Social Services	175,134		3,374	178,508		178,508		178,508			12
13	CNA Training											13
14	Program Transportation			3,479	3,479		3,479		3,479			14
15	Other (specify):*							3,207	3,207			15
16	TOTAL Health Care and Programs	3,368,152	296,478	131,229	3,795,859		3,795,859	(3,651)	3,792,208			16
	C. General Administration											
17	Administrative	200,767		1,903,743	2,104,510		2,104,510	(1,736,315)	368,195			17
18	Directors Fees											18
19	Professional Services			149,991	149,991		149,991	60,563	210,554			19
20	Dues, Fees, Subscriptions & Promotions			153,134	153,134		153,134	(123,659)	29,475			20
21	Clerical & General Office Expenses	263,776	38,554	338,449	640,779		640,779	(231,931)	408,848			21
22	Employee Benefits & Payroll Taxes			916,401	916,401	63,948	980,349	(3,721)	976,628			22
23	Inservice Training & Education			6,306	6,306		6,306		6,306			23
24	Travel and Seminar							413	413			24
25	Other Admin. Staff Transportation			4,334	4,334		4,334	(4,334)				25
26	Insurance-Prop.Liab.Malpractice			54,914	54,914		54,914	151,151	206,065			26
27	Other (specify):*			359,298	359,298		359,298	(330,341)	28,957			27
28	TOTAL General Administration	464,543	38,554	3,886,570	4,389,667	63,948	4,453,615	(2,218,174)	2,235,441			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,676,480	1,039,988	4,352,774	10,069,242		10,069,242	(2,215,794)	7,853,448			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	9,205
	REPAIRS & MAINTENANCE	3,550
	DIETARY EQUIPMENT	15,354
3	HOUSEKEEPING	
		0
		0
4	LAUNDRY	
	EQUIPMENT REPAIRS & MAINTENANCE	780
		0
5	HEAT & OTHER UTILITIES	
	GAS HEAT	66,158
	ELECTRICITY	72,628
	WATER	44,171
	CABLE TV - LOBBY	8,262
		0
6	MAINTENANCE	
	GROUNDS MAINTENANCE	14,011
	PAINTING & DECORATING	3,860
	BUILDING REPAIRS	26,871
	MAINTENANCE TRAVEL	0
	EQUIPMENT MAINTENANCE & REPAIR	37,757
	ELEVATOR MAINTENANCE & REPAIR	5,554
	OUTSIDE LABOR	0
	EXTERMINATING SERVICE	6,746
	FIRE SERVICE	3,833
		0
		0
		0
		0
7	OTHER	
	SCAVENGER	16,235
	SECURITY SERVICE	0
		0
		0
9	MEDICAL DIRECTOR	
	MEDICAL DIRECTOR FEES XVIII B 36-2	31,000

LINE	SCHED REF	TOTAL
10	NURSING	
	CONTRACT NURSING XVIII C 53-2	
	LABORATORY & XRAY EXPENSE	6,848
	PURCHASED SERVICES	0
	PSYCHO-SOCIAL CONSULTANT XVIII B -2	0
	RESTORATIVE NURSING CONSULTANT XVIII B 38-2	0
	MEDICAL RECORDS CONSULTANT XVIII B 37-2	1,176
	PHARMACY CONSULTANT XVIII B 39-2	8,632
	UTILIZATION REVIEW FEES XVIII B -2	0
	PHYSICIANS XVIII B -2	0
	PSYCHIATRIC XVIII B -2	0
	RN CONSULTANT XVIII B 38-2	0
		0
		0
10a	THERAPY	
	PHYSICAL THERAPY SERVICES	
	SPEECH THERAPY SERVICES	0
	OCCUPATIONAL THERAPY SERVICES	0
	REHABILITATION CONSULTANT XVIII B -2	0
	PHYSICAL THERAPY CONSULTANT XVIII B 40-2	0
	OCCUPATIONAL THERAPY CONSULTANT XVIII B 41-2	0
	RESPIRATORY THERAPY CONSULTANT XVIII B 42-2	3,840
	SPEECH THERAPY CONSULTANT XVIII B 43-2	0
	NURSING CONSULTANT	23,000
	NURSING PROGRAM CONSULTANT	44,000
11	ACTIVITIES	
	CABLE TV - PATIENT ROOMS	0
	ACTIVITY REHAB CONSULTANT XVIII B 44-2	5,880
		0
12	SOCIAL SERVICES	
	SOCIAL REHABILITATION SERVICES	0
	SOCIAL REHABILITATION CONSULTANT XVIII B 45-2	0
	SOCIAL WORKER XVIII B 45-2	3,374
13	NURSE AIDE TRAINING	
	NURSE AIDE TRAINING COSTS XIII	0

V.COST CENTER EXPENSES

PAGE 3 COLUMN 3 OTHER

LINE	SCHED REF	TOTAL
14	PROGRAM TRANSPORTATION	
	PATIENT TRANSPORTATION	3,479
		0
17	ADMINISTRATIVE	
	MANAGEMENT FEES XIX B	1,903,743
	DIRECTORS FEES	
18	DIRECTORS FEES	0
19	PROFESSIONAL SERVICES	
	DATA PROCESSING XIX C	58,591
	ADMINISTRATIVE CONSULTANTS XIX C	0
	PROFESSIONAL FEES XIX C	91,400
		0
		149,991
20	FEES,SUBSCRIPTIONS,PROMOTIONS	
	ENTERTAINMENT & MARKETING VI 19 XIX F	0
	ADV & PROMO-NON PATIENT RELATED VI 25 XIX F	47,982
	EMPLOYEE WANT ADS XIX F	0
	CONTRIBUTIONS VI 20 XIX F	69,349
	DUES & SUBSCRIPTIONS XIX F	15,547
	LICENSES & PERMITS XIX F	4,787
	PUBLIC RELATIONS-PATIENT RELATED XIX F	0
	ADVERTISING-YELLOW PAGES VI 28 XIX F	0
	TRUST FEES / FRANCHISE TAX / ETC VI 17 XIX F	0
	CONTRIBUTIONS - POLITICAL VI 20 XIX F	6,823
	HEALTH CARE WORKER BACKGROUND CHEC XIX F	8,646
	PATIENT BACKGROUND CHECKS XIX F	0
		153,134
21	CLERICAL & GENERAL OFFICE EXPENSES	
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)	1,231
	EQUIPMENT REPAIR & MAINTENANCE	1,329
	OUTSIDE CLERICAL SERVICES	285,438
	PENALTIES / OVERDRAFT CHARGES VI 18	3,710
	HOME OFFICE EXPENSE	0
	THEFT & DAMAGE LOSS	0
	TELEPHONE	46,741
	MESSENGER SERVICE	0
		0
		338,449

LINE	SCHED REF	TOTAL
22	EMPLOYEE BENEFITS & PAYROLL TAXES	
	FICA TAXES XIX D	349,715
	UNEMPLOYMENT COMPENSATION XIX D	30,400
	WORKERS COMPENSATION INSURANC XIX D	189,470
	HOSPITALIZATION INSURANCE XIX D	262,423
	EMPLOYEE BENEFITS - OTHER XIX D	40,361
	EMPLOYEE PHYSICAL EXAMS XIX D	2,373
	INSURANCE - EXECUTIVE LIFE VI 21/XIX D	3,721
	PENSION/PROFIT SHARING PLANS XIX D	29,586
	CHICAGO HEAD TAX XIX D	6,480
	PAYROLL TAXES - LEGACY	1,872
		916,401
23	INSERVICE TRAINING & EDUCATION	
	EDUCATION & SEMINARS	6,306
		6,306
24	TRAVEL & SEMINARS	
	EDUCATION & SEMINARS XIX G	0
	TRAVEL XIX G	0
		0
25	ADMIN. STAFF TRANSPORTATION	
	TRANSPORTATION - STAFF	4,334
		4,334
26	INSURANCE - PROP. LIAB & MALPRACTICE	
	GENERAL INSURANCE	54,914
		54,914
27	OTHER	
	BAD DEBTS VI 24	359,298
		359,298

GRAND TOTAL COLUMN 3 OTHER

4,352,774

**PETERSON PARK HEALTH CARE CENTER
SCHEDULES
12/31/2011**

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

TOTAL FOOD PURCHASE	498,151
LESS SALES TAX	<u>(2,654)</u>
NET FOOD	495,497
TOTAL PATIENT CENSUS	65,795
TIME 3 MEALS PER DAY	<u>3</u>
TOTAL PATIENT MEALS	197,385
ADD # EMPLOYEE MEALS/DAY	80
TIME # DAYS	<u>365</u>
TOTAL EMPLOYEE MEALS	29,200
PATIENT MEALS	197,385
ADD EMPLOYEE MEALS	<u>29,200</u>
TOTAL MEALS/YEAR	226,585
NET FOOD	495,497
DIVIDE TOTAL MEALS/YEAR	<u>226,585</u>
COST PER MEAL	2.19
TIME EMPLOYEE MEALS	<u>29,200</u>
EMPLOYEE MEAL RECLASSIFICATION	63,948
	=====

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation							264,759	264,759			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			28,652	28,652		28,652	269,452	298,104			32
33	Real Estate Taxes							236,923	236,923			33
34	Rent-Facility & Grounds			1,066,860	1,066,860		1,066,860	(1,066,860)				34
35	Rent-Equipment & Vehicles			10,088	10,088		10,088		10,088			35
36	Other (specify):*							26,769	26,769			36
37	TOTAL Ownership			1,105,600	1,105,600		1,105,600	(268,957)	836,643			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		288,730	870,644	1,159,374		1,159,374		1,159,374			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			102,930	102,930		102,930		102,930			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		288,730	973,574	1,262,304		1,262,304		1,262,304			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	4,676,480	1,328,718	6,431,948	12,437,146		12,437,146	(2,484,751)	9,952,395			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.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 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	(31,986)	30		9
10	Interest and Other Investment Income	(36,863)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(2,654)	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	(3,710)	21		18
19	Entertainment		20		19
20	Contributions	(76,172)	20		20
21	Owner or Key-Man Insurance	(3,721)	22		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(359,298)	27		24
25	Fund Raising, Advertising and Promotional	(47,982)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising		20		28
29	Other-Attach Schedule	(128,485)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (690,871)		\$	30

BHF USE ONLY								
48		49		50		51		52

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 Amount	2 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)	(1,793,880)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (1,793,880)		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (2,484,751)		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 Yes	2 No	3 Amount	4 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

STATE OF ILLINOIS

PETERSON PARK HEALTH CARE CENTER

Report Period Beginning:

Ending:

ID#

0024463

01/01/2011

12/31/2011

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	DEFERRED MAINTENANCE	\$	6	1
2	BANK CHARGES	(1,231)	21	2
3	MANAGEMENT FEES- CHAIM RAJCHENBACH	(30,000)	17	3
4	MANAGEMENT FEES- MENACHEM SHABAT	(45,000)	17	4
5	STAFF TRANSPORTATION	(4,334)	25	5
6	MARKETING SALARY	(47,920)	21	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	(128,485)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number PETERSON PARK HEALTH CARE CENTER # 0024463 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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	(2,654)	0	103	0	0	0	0	0	0	0	0	(2,551)	2
3	Housekeeping	0	0	1,089	0	0	0	0	0	0	0	0	1,089	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	2,252	0	0	0	0	0	0	0	0	2,252	5
6	Maintenance	0	0	5,241	0	0	0	0	0	0	0	0	5,241	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(2,654)	0	8,685	0	0	0	0	0	0	0	0	6,031	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	(6,858)	0	0	0	0	0	0	(6,858)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	3,207	0	0	0	0	0	0	3,207	15
16	TOTAL Health Care and Programs	0	0	0	0	(3,651)	0	0	0	0	0	0	(3,651)	16
	C. General Administration													
17	Administrative	(75,000)	0	(299,065)	0	0	(1,362,250)	0	0	0	0	0	(1,736,315)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	56,287	4,028	0	248	0	0	0	0	0	0	60,563	19
20	Fees, Subscriptions & Promotions	(124,154)	372	57	29	37	0	0	0	0	0	0	(123,659)	20
21	Clerical & General Office Expenses	(52,861)	0	(179,140)	0	70	0	0	0	0	0	0	(231,931)	21
22	Employee Benefits & Payroll Taxes	(3,721)	0	0	0	0	0	0	0	0	0	0	(3,721)	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	413	0	0	0	0	0	0	0	0	413	24
25	Other Admin. Staff Transportation	(4,334)	0	0	0	0	0	0	0	0	0	0	(4,334)	25
26	Insurance-Prop.Liab.Malpractice	0	150,740	411	0	0	0	0	0	0	0	0	151,151	26
27	Other (specify):*	(359,298)	0	24,796	0	0	4,161	0	0	0	0	0	(330,341)	27
28	TOTAL General Administration	(619,368)	207,399	(448,500)	29	355	(1,358,089)	0	0	0	0	0	(2,218,174)	28
	TOTAL Operating Expense													
29	(sum of lines 8,16 & 28)	(622,022)	207,399	(439,815)	29	(3,296)	(1,358,089)	0	0	0	0	0	(2,215,794)	29

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
30	Depreciation	(31,986)	289,989	671	6,085	0	0	0	0	0	0	0	264,759	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(36,863)	300,363	7	5,945	0	0	0	0	0	0	0	269,452	32
33	Real Estate Taxes	0	231,415	0	5,508	0	0	0	0	0	0	0	236,923	33
34	Rent-Facility & Grounds	0	(1,066,860)	16,027	(16,027)	0	0	0	0	0	0	0	(1,066,860)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	26,769	0	0	0	0	0	0	0	0	0	26,769	36
37	TOTAL Ownership	(68,849)	(218,324)	16,705	1,511	0	0	0	0	0	0	0	(268,957)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(690,871)	(10,925)	(423,110)	1,540	(3,296)	(1,358,089)	0	0	0	0	0	(2,484,751)	45

VII. RELATED PARTIES

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

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

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	\$ 1,066,860	PETERSON PARK REALTY		\$	\$ (1,066,860)	1
2	V								2
3	V	19	PROF FEES		PETERSON PARK REALTY		56,287	56,287	3
4	V	33	PROF. FEES - R/E REDUCTION		PETERSON PARK REALTY		5,129	5,129	4
5	V	20	LICENSES & FEES		PETERSON PARK REALTY		372	372	5
6	V	26	INSURANCE - GENERAL		PETERSON PARK REALTY		150,740	150,740	6
7	V	30	DEPRECIATION		PETERSON PARK REALTY		289,989	289,989	7
8	V	32	INTEREST		PETERSON PARK REALTY		300,363	300,363	8
9	V	33	REAL ESTATE TAXES		PETERSON PARK REALTY		226,286	226,286	9
10	V	36	INSURANCE H.U.D. (MIP)		PETERSON PARK REALTY		26,769	26,769	10
11	V								11
12	V								12
13	V								13
14	Total			\$ 1,066,860			\$ 1,055,935	\$ * (10,925)	14

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

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES ☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	17	MANAGEMENT FEES	\$ 371,065	LEGACY HEALTHCARE FINANCIAL SERVICES LLC		\$	\$ (371,065)	15
16	V	21	OUTSIDE CLERICAL	285,000	LEGACY HEALTHCARE FINANCIAL SERVICES LLC			(285,000)	16
17	V	2	FOOD		LEGACY HEALTHCARE FINANCIAL SERVICES LLC		103	103	17
18	V	3	HOUSEKEEPING		LEGACY HEALTHCARE FINANCIAL SERVICES LLC		1,089	1,089	18
19	V	5	UTILITIES		LEGACY HEALTHCARE FINANCIAL SERVICES LLC		2,252	2,252	19
20	V	6	GROUNDS & MAINTENANCE		LEGACY HEALTHCARE FINANCIAL SERVICES LLC		5,241	5,241	20
21	V	17	MANAGEMENT FEES		LEGACY HEALTHCARE FINANCIAL SERVICES LLC		72,000	72,000	21
22	V	19	PROFESSIONAL FEES		LEGACY HEALTHCARE FINANCIAL SERVICES LLC		4,028	4,028	22
23	V	20	FEES,SUBSCRIPTIONS		LEGACY HEALTHCARE FINANCIAL SERVICES LLC		57	57	23
24	V	21	CLERICAL & GENERAL		LEGACY HEALTHCARE FINANCIAL SERVICES LLC		105,860	105,860	24
25	V	24	SEMINARS		LEGACY HEALTHCARE FINANCIAL SERVICES LLC		413	413	25
26	V	26	INSURANCE		LEGACY HEALTHCARE FINANCIAL SERVICES LLC		411	411	26
27	V	27	EMPL BENEFITS-GEN ADMIN		LEGACY HEALTHCARE FINANCIAL SERVICES LLC		24,796	24,796	27
28	V	30	DEPRECIATION		LEGACY HEALTHCARE FINANCIAL SERVICES LLC		671	671	28
29	V	32	INTEREST		LEGACY HEALTHCARE FINANCIAL SERVICES LLC		7	7	29
30	V	34	RENT		LEGACY HEALTHCARE FINANCIAL SERVICES LLC		16,027	16,027	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			\$ 656,065			\$ 232,955	\$ * (423,110)	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	\$ 16,027	LEGACY REAL PROPERTIES LLC		\$	(16,027)	15
16	V	20	DUES & SUBSCRIPTIONS		LEGACY REAL PROPERTIES LLC		29	29	16
17	V	30	DEPRECIATION		LEGACY REAL PROPERTIES LLC		6,085	6,085	17
18	V	32	INTEREST EXPENSE		LEGACY REAL PROPERTIES LLC		5,945	5,945	18
19	V	33	REAL ESTATE TAXES		LEGACY REAL PROPERTIES LLC		5,508	5,508	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			\$ 16,027			\$ 17,567	\$ * 1,540	39

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

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES ☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	10	NURSE CONSULTING	\$ 46,000	PROGRESSIVE HEALTHCARE CONSULTING		\$	(46,000)	15
16	V	10	RN SALARIES		PROGRESSIVE HEALTHCARE CONSULTING		39,142	39,142	16
17	V	15	EMPLOYEE BENEFITS		PROGRESSIVE HEALTHCARE CONSULTING		3,207	3,207	17
18	V	19	PROFESSIONAL FEES		PROGRESSIVE HEALTHCARE CONSULTING		248	248	18
19	V	20	FEES, SUBSCRIPTIONS		PROGRESSIVE HEALTHCARE CONSULTING		37	37	19
20	V	21	CLERICAL AND GENERAL		PROGRESSIVE HEALTHCARE CONSULTING		70	70	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			\$ 46,000			\$ 42,704	\$ * (3,296)	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.

☒ X

 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	\$ 1,457,678	SHABAT & ASSOCIATES		\$	(1,457,678)	15
16	V	17	SALARY- RON SHABAT		SHABAT & ASSOCIATES		95,428	95,428	16
17	V	27	PAYROLL TAXES		SHABAT & ASSOCIATES		4,161	4,161	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			\$ 1,457,678			\$ 99,589	\$ * (1,358,089)	39

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

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1								1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number PETERSON PARK HEALTH CARE CENT # 0024463 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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	39.00	SEE ATTACHED			Salary/Fees	\$ 200,000	17-1;17-7	1
2	CHAIM RAJCHENBACH	RELATIVE	Administrative		SEE ATTACHED			SALARY	36,000	17-3	2
3	MENACHEM SHABAT	OWNER	Administrative	6.38	SEE ATTACHED			SALARY	36,000	17-3	3
4	CHAIM SHABAT	RELATIVE	ASST. ADMIN.		NONE			SALARY	11,686	17-1	4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 283,686		13

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

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

Facility Name & ID Number PETERSON PARK HEALTH CARE CENTER # 0024463 Report Period Beginning: 01/01/2011 Ending: 2/31/2011

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization PETERSON PARK HEALTH CARE REALTY
Street Address 6141 NORTH PULASKI RD
City / State / Zip Code CHICAGO, IL 60646
Phone Number (773) 478-2000
Fax Number (773) 478-8408

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
	1	19	PROF FEES	DIRECT	1	\$ 56,287	\$	1	\$ 56,287	1
	2	33	PROF. FEES - R/E REDUCTION	DIRECT	1	5,129		1	5,129	2
	3	20	LICENSES & FEES	DIRECT	1	372		1	372	3
	4	26	INSURANCE - GENERAL	DIRECT	1	150,740		1	150,740	4
	5	30	DEPRECIATION	DIRECT	1	289,989		1	289,989	5
	6	32	INTEREST	DIRECT	1	300,363		1	300,363	6
	7	33	REAL ESTATE TAXES	DIRECT	1	226,286		1	226,286	7
	8	36	INSURANCE H.U.D. (MIP)	DIRECT	1	26,769		1	26,769	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				\$ 1,055,935	\$		\$ 1,055,935	25

Facility Name & ID Number PETERSON PARK HEALTH CARE CENTER # 0024463 Report Period Beginning: 01/01/2011 Ending: 2/31/2011

VIII. ALLOCATION OF INDIRECT COSTS

- A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐
- B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization 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

	1	2	3	4	5	6	7	8	9	
	Schedule V		Unit of Allocation		Number of	Total Indirect	Amount of Salary	Facility	Allocation	
	Line	Item	(i.e.,Days, Direct Cost,	Total Units	Subunits Being	Cost Being	Cost Contained	Units	(col.8/col.4)x col.6	
	Reference		Square Feet)		Allocated Among	Allocated	in Column 6			
1	2	FOOD	Bed Days Available	590,233	12	\$ 890	\$	68,620	\$ 103	1
2	3	HOUSEKEEPING	Bed Days Available	590,233	12	9,370	9,260	68,620	1,089	2
3	5	UTILITIES	Bed Days Available	590,233	12	19,367		68,620	2,252	3
4	6	GROUNDS & MAINTENANCE	Bed Days Available	590,233	12	45,083	9,228	68,620	5,241	4
5	17	MANAGEMENT FEES	WEIGHTED AVERAGE	50	11	400,000		9	72,000	5
6	19	PROFESSIONAL FEES	Bed Days Available	590,233	12	34,648		68,620	4,028	6
7	20	FEES,SUBSCRIPTIONS	Bed Days Available	590,233	12	493		68,620	57	7
8	21	CLERICAL & GENERAL	Bed Days Available	590,233	12	910,553	832,276	68,620	105,860	8
9	24	SEMINARS	Bed Days Available	590,233	12	3,552		68,620	413	9
10	26	INSURANCE	Bed Days Available	590,233	12	3,535		68,620	411	10
11	27	EMPL BENEFITS-GEN ADMIN	Bed Days Available	590,233	12	213,280		68,620	24,796	11
12	30	DEPRECIATION	Bed Days Available	590,233	12	5,774		68,620	671	12
13	32	INTEREST	Bed Days Available	590,233	12	62		68,620	7	13
14	34	RENT	Bed Days Available	590,233	12	137,855		68,620	16,027	14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 1,784,462	\$ 850,764		\$ 232,955	25

Facility Name & ID Number PETERSON PARK HEALTH CARE CENTER # 0024463 Report Period Beginning: 01/01/2011 Ending: 2/31/2011

VIII. ALLOCATION OF INDIRECT COSTS

- A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐
- B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization 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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
	1	20	DUES & SUBSCRIPTIONS	Bed Days Available	590,233	12	\$ 250	\$ 68,620	\$ 29	1
	2	30	DEPRECIATION	Bed Days Available	590,233	12	52,340	68,620	6,085	2
	3	32	INTEREST EXPENSE	Bed Days Available	590,233	12	51,132	68,620	5,945	3
	4	33	REAL ESTATE TAXES	Bed Days Available	590,233	12	47,377	68,620	5,508	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				\$ 151,099	\$		\$ 17,567	25

Facility Name & ID Number PETERSON PARK HEALTH CARE CENTER # 0024463 Report Period Beginning: 01/01/2011 Ending: 2/31/2011

VIII. ALLOCATION OF INDIRECT COSTS

- A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐
- B. Show the allocation of costs below. If necessary, please attach worksheets.

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
	1	<u>RN SALARIES</u>	Bed Days Available	465,768	10	\$ 265,681	\$ 265,861	68,620	\$ 39,142	1
	2	<u>EMPLOYEE BENEFITS</u>	Bed Days Available	465,768	10	21,767		68,620	3,207	2
	3	<u>PROFESSIONAL FEES</u>	Bed Days Available	465,768	10	1,681		68,620	248	3
	4	<u>FEES, SUBSCRIPTIONS</u>	Bed Days Available	465,768	10	250		68,620	37	4
	5	<u>CLERICAL AND GENERAL</u>	Bed Days Available	465,768	10	472		68,620	70	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				\$ 289,851	\$ 265,861		\$ 42,704	25

Facility Name & ID Number PETERSON PARK HEALTH CARE CENTER # 0024463 Report Period Beginning: 01/01/2011 Ending: 2/31/2011

VIII. ALLOCATION OF INDIRECT COSTS

- A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐
- B. Show the allocation of costs below. If necessary, please attach worksheets.

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	SALARY- RON SHABAT	DIRECT	1	1	\$ 95,428	\$ 95,428	1	\$ 95,428	1
2	27	PAYROLL TAXES	DIRECT	1	1	4,161		1	4,161	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					\$ 99,589	\$ 95,428		\$ 99,589	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		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related Long-Term												
1	HEARTLAND BANK		X	MORTGAGE	\$39,040.00	10/16/04	\$ 6,296,100	\$ 5,291,277	11/01/29	0.0560	\$ 300,363	1	
2												2	
3												3	
4												4	
5												5	
	Working Capital												
6	BANK FINANCIAL		X	WORKING CAPITAL	INT	REVOLV		2,639,812	REVOLV	PRIME+	28,291	6	
7											361	7	
8	ALLOCATION										5,952	8	
9	TOTAL Facility Related				\$39,040.00		\$ 6,296,100	\$ 7,931,089			\$ 334,967	9	
	B. Non-Facility Related*												
10												10	
11	INTEREST INCOME-BLDG											11	
12												12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$	14	
15	TOTALS (line 9+line14)						\$ 6,296,100	\$ 7,931,089			\$ 334,967	15	

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 26,769 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

[illegible]

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.**

2010 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME PETERSON PARK HEALTH CARE CENTER COUNTY COOK

FACILITY IDPH LICENSE NUMBER 0024463

CONTACT PERSON REGARDING THIS REPORT BOB KAGDA

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

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2010 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2010.

	(A)	(B)	(C)	(D)
	<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
1.	<u>13-02-115-052-0000</u>	<u>NURSING HOME</u>	\$ <u>230,634.80</u>	\$ <u>230,634.80</u>
2.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
3.	<u>10-35-104-076-0000</u>	<u>HOME OFFICE ALLOCATION</u>	\$ <u>40,915.78</u>	\$ <u>4,756.83</u>
4.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
5.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
6.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
7.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
8.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
9.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
10.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
		TOTALS	\$ <u><u>271,550.58</u></u>	\$ <u><u>235,391.63</u></u>

B. **Real Estate Tax Cost Allocations**

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

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

C. **Tax Bills**

Attach a copy of the original 2010 tax bills which were listed in Section A to this statement. Be sure to use the 2010 tax bill which is normally paid during 2011.

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 BRICKFrameNumber 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	FACILITY		1986	\$ 283,071	1
2	alloc fr Legacy RP			9,511	2
3	TOTALS			\$ 292,582	3

Facility Name & ID Number PETERSON PARK HEALTH CARE CENTER

0024463

Report Period Beginning:

01/01/2011

Ending:

12/31/2011

XI. OWNERSHIP COSTS (continued)

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

	1	FOR BHF USE ONLY	2	3	4	5	6	7	8	9	
	Beds*		Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	188		1986		\$ 2,548,850	\$ 129,491	35	\$ 72,824	\$ (56,667)	\$ 1,893,424	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	14,162	16
17	VARIOUS		1988		35,577		31	1,147	1,147	26,762	17
18	VARIOUS		1989		14,591		31	470	470	10,529	18
19	VARIOUS		1990		27,693		31	894	894	19,119	19
20	VARIOUS		1991		62,352		20	2,300	2,300	62,352	20
21	VARIOUS		1992		10,152		20	502	502	10,152	21
22	VARIOUS		1993		21,815		20	1,092	1,092	20,315	22
23	VARIOUS		1994		264,384		20	13,226	13,226	228,228	23
24	VARIOUS		1995		103,507		20	5,176	5,176	85,163	24
25	VARIOUS		1996		35,086		20	1,757	1,757	27,337	25
26	VARIOUS		1997		62,950		20	3,150	3,150	45,350	26
27	VARIOUS		1998		49,698		20	2,487	2,487	34,111	27
28	VARIOUS		1999		87,532		20	4,383	4,383	56,179	28
29	VARIOUS		2000		188,443		20	9,427	9,427	108,638	29
30	VARIOUS		2001		73,918		20	3,700	3,700	39,482	30
31	VARIOUS		2002		350,099		20	17,508	17,508	166,312	31
32	VARIOUS		2003		78,238		20	3,908	3,908	33,242	32
33	VARIOUS		2004		66,172		20	3,309	3,309	24,794	33
34	VARIOUS		2005		53,841		20	2,693	2,693	17,187	34
35	VARIOUS		2006		50,608		20	2,531	2,531	13,912	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 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 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	\$ 129,491		\$ 153,056	\$ 23,565	\$ 3,168,179	70

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

Facility Name & ID Number PETERSON PARK HEALTH CARE CENTER

0024463

Report Period Beginning:

01/01/2011 Ending: 12/31/2011

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	\$ 129,491		\$ 153,056	\$ 23,565	\$ 3,168,179	1
2	CONCRETE DOCK	2007	3,500		15	233	233	1,039	2
3	REHAB NURSING STATION	2007	11,394		20	570	570	2,565	3
4	RENOVATION 1ST FLOOR CORRIDOR AND LOBBY	2007	255,996		20	12,800	12,800	57,600	4
5	RENOVATION THERAPY REHAB ROOM	2007	12,744		20	637	637	2,867	5
6	SECURITY SYSTEM	2007	6,100		20	305	305	1,372	6
7	ROOF	2007	17,600		20	880	880	1,980	7
8	5 TON MULGIAGUA R-22 PACKGD ELECTRIC HIGH EFF	2007	32,940		20	1,647	1,647	7,412	8
9	CABLE WIRING	2007	12,500		20	625	625	2,812	9
10	NURSE CALL SYSTEM	2007	10,612		20	531	531	2,389	10
11	CIRCULATION OF HOT WATER LINES	2007	8,770		20	439	439	1,975	11
12	REAR ENTRANCE DOOR	2007	3,308		20	165	165	743	12
13	ELEVATOR REHAB 4 NEW NYLON PLATED GUILDE SHOE	2007	3,297		20	165	165	743	13
14	LANDSCAPING	2008	16,600		15	1,107	1,107	3,875	14
15	AWNING	2008	3,500		27.5	127	127	469	15
16	ELEVATOR REHAB	2008	5,500		27.5	200	200	738	16
17	ROOF	2008	4,000		27.5	145	145	535	17
18	COOPER PIPING	2008	2,860		27.5	104	104	384	18
19	CABLE WIRING	2008	3,850		27.5	140	140	516	19
20	A/C UNITS	2008	4,497		27.5	163	163	601	20
21	GATE VALVES	2008	2,800		27.5	102	102	376	21
22	NURSE CALL SYSTEM	2008	11,990		27.5	436	436	1,608	22
23	REPLACE HOT WATER & CIRCULATION LINES	2008	3,900		27.5	142	142	524	23
24	CABLE WIRING	2008	10,460		27.5	380	380	1,402	24
25	HOT WATER LINES	2008	7,500		27.5	273	273	1,007	25
26	A/C UNITS WITH SLEEVES	2008	3,951		27.5	144	144	531	26
27	BUILD IN WARDROBE CABINETS	2008	20,641		27.5	751	751	2,769	27
28	PAINTING	2009	39,906		20	1,995	1,995	7,981	28
29	SHADES, CORNICES & PANELS	2009	51,425		20	2,571	2,571	10,285	29
30	FLOORING & CARPETING	2009	5,410		20	271	271	1,083	30
31	WALLCOVERING, CORNICES & PANELS	2009	10,770		20	539	539	2,155	31
32	VINYL FLOORING	2009	5,481		20	274	274	1,096	32
33	SMOKE DETECTORS	2009	7,000		27.5	255	255	584	33
34	TOTAL (lines 1 thru 33)		\$ 5,035,466	\$ 129,491		\$ 182,172	\$ 52,681	\$ 3,290,195	34

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

Facility Name & ID Number PETERSON PARK HEALTH CARE CENTER

0024463

Report Period Beginning:

01/01/2011 Ending: 12/31/2011

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 5,035,466	\$ 129,491		\$ 182,172	\$ 52,681	\$ 3,290,195	1
2	GREASE TRAPS	2009	2,790		27.5	101	101	232	2
3	RECONDITION BOILER	2009	6,405		27.5	233	233	534	3
4	HOT WATER LINE	2009	5,180		27.5	188	188	431	4
5	WATER HEATER	2009	3,650		27.5	133	133	305	5
6	NURSE CALL SYSTEM	2009	21,666		27.5	788	788	1,806	6
7	HOT WATER & CIRCULATION LINE	2009	5,420		27.5	197	197	451	7
8	HOW WATER & CIRCULATION PIPES	2009	4,760		27.5	173	173	396	8
9	DRYWALL	2009	2,500		27.5	91	91	209	9
10	COPPER PIPING	2009	5,700		27.5	207	207	474	10
11	BATHROOM REMOD - LAVATORY, LIGHT FIX, WALL TOV	2009	12,407		27.5	451	451	1,034	11
12	CHAIR RAIL	2009	4,329		27.5	157	157	360	12
13	DRYWALL & DRAINS FOR 2 BATHTUBS	2009	5,600		27.5	204	204	467	13
14	PATIO	2009	10,390		15	693	693	1,646	14
15									15
16									16
17									17
18	DRYWALL METAL STUDS TIME & CONVERT TUB 2 SHOW	2010	4,450		20	223	223		18
19	ROOM SIGNS	2010	12,108		20	605	605		19
20	CLINICAL SINKS	2010	7,121		20	356	356		20
21	PLUMBING IN UTILITY ROOM	2010	9,651		20	483	483		21
22	SIGN	2010	13,700		15	457	457	1,370	22
23	NURSES STATION - PANELS, BOARDS, GRANITE TOPS	2010	30,280		20	1,839	1,839		23
24	REHAB BATHROOM - ARCHITECT FEES	2010	4,170		20	209	209		24
25	REHAB BATHROOM - FAUCETS, LIGHTING, FLOORS	2010	32,452		20	1,623	1,623		25
26	CORRIDOR & DAY ROOM RENOV - COVE BASE, WINDOW	2010	172,082		20	8,604	8,604		26
27	SOILED UTILITY ROOM RENOVATION - CABINETS, SINK	2010	23,598		20	1,180	1,180		27
28	REHAB BATHROOMS - WALLS, LIGHTING, FLOORS	2010	77,780		20	3,889	3,889		28
29	CORRIDOR RENOVATION - WALLS, CHAIR RAILS, FLOOR	2010	172,732		20	8,637	8,637		29
30	TILING & WALLCOVERING FOR FOYER	2010	3,549		20	177	177		30
31	GENERATOR REPAIR	2010	2,526		20	126	126		31
32	THRU THE WALL HEATING & A/C UNITS	2010	5,626		20	281	281		32
33	SINKS & FAUCETS	2010	3,270		20	164	164		33
34	TOTAL (lines 1 thru 33)		\$ 5,701,358	\$ 129,491		\$ 214,641	\$ 85,150	\$ 3,299,910	34

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

Facility Name & ID Number PETERSON PARK HEALTH CARE CENTER

0024463

Report Period Beginning:

01/01/2011 Ending: 12/31/2011

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 12C, Carried Forward		\$ 5,701,358	\$ 129,491		\$ 214,641	\$ 85,150	\$ 3,299,910	1
2	TILING, PAINTING & REMODEL SOCIAL ROOM HALL OFF	2010	15,730		20				2
3	DRYWALL	2010	3,920		20				3
4	CHANGE LOCKS	2010	4,481		20				4
5	REMODEL PUBLIC BATHROOMS FLOOR WALL TOILET L	2010	7,503		20				5
6	SHUT OFF VALVE & ACCESS PANELS IN SOILED UTLY RM	2010	3,994		20				6
7	REPLACE DRYWALL & STUDS IN BATHROOM	2010	2,930		20				7
8	REPLACE EXISTING TILE & BASEBOARDS & PAINT WALL	2010	9,990		20				8
9	REPLACE DRYWALL & STUDS & PAINTING	2010	7,918		20				9
10	REBUILT EJECTOR PUMP	2010	5,400		20				10
11	BATHROOM RESTORATION - WALLS & DRAINS	2010	9,350		20				11
12	RADIATOR HEATING SYSTEM	2010	9,590		20				12
13	HANDRAILS, BUMPERS, DOOR KNOBS	2010	4,350		20				13
14	TILING & BASEBOARDS, WALLS, CEILINGS, PAINT	2010	12,995		20				14
15	KITCHEN & EXHAUST FAN DUCTS, ELECTRICAL	2010	3,522		20				15
16	PAINTING & SINK IN MED ROOM	2010	6,470		20				16
17	DRYWALL, TILING, RAISING NURSE CALL SWITCHES	2010	4,050		20				17
18	PUMP REPAIRS/PUMP SEAL KIT	2010	2,642		20				18
19	ROOF - DRAINAGE	2010	2,600		20				19
20	DRAIN WATER LINE	2010	2,800		20				20
21	GLASS WALL/DOOR	2010	14,800		20				21
22	EMERGENCY/EXIT DOORS/DOOR OPENER	2010	4,200		20				22
23	ELECTRIAL & LIGHTING	2010	7,720		20				23
24	SIX WINDOWS	2010	3,000		20				24
25	HOT WATER TANK	2010	14,680		20				25
26	BEAUTY MIRROR INSTALLATION	2010	2,500		20				26
27									27
28	ARCHITECT FEES	2011	6,000		27.5	173	173	173	28
29	CUSTOM CABINETS BUILD IT SECURED TO WALL	2011	2,800		27.5	81	81	81	29
30	SEWER PUMP MOTOR	2011	2,910		27.5	84	84	84	30
31	ARCHITECT FEES	2011	6,474		27.5	186	186	186	31
32	BOILERS	2011	63,550		27.5	1,829	1,829	1,829	32
33	DOORS WINDOWS & THERMOBRAKE METAL	2011	16,100		27.5	317	317	317	33
34	TOTAL (lines 1 thru 33)		\$ 5,966,327	\$ 129,491		\$ 217,311	\$ 87,820	\$ 3,302,580	34

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

Facility Name & ID Number PETERSON PARK HEALTH CARE CENTER

0024463

Report Period Beginning:

01/01/2011 Ending: 12/31/2011

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		\$ 5,966,327	\$ 129,491		\$ 217,311	\$ 87,820	\$ 3,302,580	1
2	MILLWORK & TRIM	2011	2,600		27.5	27	27	27	2
3	ELECTRIAL WORK IN BOILER/ELECTRICAL ROOM	2011	7,800		27.5	83	83	83	3
4	SPRINKLER SYSTEM CONNECTION	2011	3,900		27.5	41	41	41	4
5	INSTALL 2 NEW DEDICATED CIRCUITS NEW WASH/DRYR	2011	2,800		27.5	30	30	30	5
6	HIGH EFFICENCY CONDENSER	2011	4,250		27.5	45	45	45	6
7	REPLACE KITCHEN TILE	2011	4,230		27.5	19	19	19	7
8	REPLACE KITCHEN TILE	2011	3,865		27.5	18	18	18	8
9	HOT WATER BOILER REPAIRS	2011	7,250		27.5	33	33	33	9
10	DRAIN LINE REPLACEMENT	2011	2,700		27.5	12	12	12	10
11	SECURITY KEYPAD & WIRING FOR ELEVATOR	2011	5,950		27.5	27	27	27	11
12	REPLACE KITCHEN TILE	2011	3,975		27.5	18	18	18	12
13	CONCRETE WORK	2011	19,140		15	638	638	638	13
14	CANOPYS	2011	14,890		15	497	497	497	14
15	LANDSCAPE IRRIGATION SYSTEM	2011	11,880		15	396	396	396	15
16	PLANT INSTALLATION	2011	19,030		15	635	635	635	16
17	CORNICES, BLINDS, SHEERS	2011	10,058		5	1,006	1,006	1,006	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)		\$ 6,090,645	\$ 129,491		\$ 220,836	\$ 91,345	\$ 3,306,105	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	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		\$ 6,090,645	\$ 129,491		\$ 220,836	\$ 91,345	\$ 3,306,105	1
2								2
3								3
4								4
5	2009	73,692	2,409	35	2,456	47		5
6								6
7								7
8								8
9								9
10	2009	41,849	965	20	2,092	1,127		10
11	2010	12,725	299	20	509	210		11
12	2011	18,087	399	20		(399)		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		\$ 6,236,998	\$ 133,563		\$ 225,893	\$ 92,330	\$ 3,306,105	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	\$297,515	\$	\$29,752	\$29,752	10 YRS	\$123,274	71
72	Current Year Purchases	138,220	160,498	6,911	(153,587)	10 YRS	6,911	72
73	Fully Depreciated Assets	1,169,943					1,169,943	73
74	MGMT ALLOC	22,026	2,684	2,203	(481)		4,105	74
75	TOTALS	\$1,627,704	\$163,182	\$38,866	\$(124,316)		\$1,304,233	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	80

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$8,157,284	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$296,745	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$264,759	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$(31,986)	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$4,610,338	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: N/A
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions.
- ☐ YES☐ NO

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

**

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease
-

9. Option to Buy:
- ☐ YES☐ NO
- Terms:
- *

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

15. Is Movable equipment rental included in building rental?
- ☐ YES☐ NO
16. Rental Amount for movable equipment: \$ 2,135
- 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		2010 LEXUS RX350	660.00	7,953	18
19					19
20					20
21	TOTAL		\$ 660.00	\$ 7,953	21

10. Effective dates of current rental agreement:

Beginning

Ending

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

	Fiscal Year Ending	Annual Rent
12.	/2012	\$
13.	/2013	\$
14.	/2014	\$

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

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

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

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

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

☐ YES

☒ NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

COMMUNITY COLLEGE

HOURS PER CNA

☐

☐

☐

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

HOURS PER CNA

☐

☐

THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES

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

- (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.

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	

- (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.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39-3	hrs	\$		\$ 381,867	\$		\$ 381,867	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			140,709			140,709	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			328,532			328,532	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 prescrpts				288,730		288,730	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): RADIOLOGY					19,536			19,536	13
14	TOTAL			\$		\$ 870,644	\$ 288,730		\$ 1,159,374	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.

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 45,679	\$ 46,910	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (265,000))	4,694,085	4,694,085	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	60,916	176,971	6
7	Other Prepaid Expenses	25,662	482,628	7
8	Accounts Receivable (owners or related parties)	2,836,784	431,631	8
9	Other(specify): medicare co ins pass thru	298,556	298,556	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 7,961,682	\$ 6,130,781	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		102,484	13
14	Buildings, at Historical Cost		2,548,850	14
15	Leasehold Improvements, at Historical Cost		3,400,034	15
16	Equipment, at Historical Cost		1,616,678	16
17	Accumulated Depreciation (book methods)		(5,121,852)	17
18	Deferred Charges		111,770	18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): security deposit	23,760	27,521	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 23,760	\$ 2,685,485	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 7,985,442	\$ 8,816,266	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 810,017	\$ 819,517	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	258	258	28
29	Short-Term Notes Payable	2,639,812	2,639,812	29
30	Accrued Salaries Payable	639,806	639,806	30
31	Accrued Taxes Payable (excluding real estate taxes)	76,810	76,810	31
32	Accrued Real Estate Taxes(Sch.IX-B)		230,635	32
33	Accrued Interest Payable		24,693	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36			176,655	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 4,166,703	\$ 4,608,186	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		5,114,622	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$ 5,114,622	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 4,166,703	\$ 9,722,808	46
47	TOTAL EQUITY(page 18, line 24)	\$ 3,818,739	\$ (906,542)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 7,985,442	\$ 8,816,266	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 2,757,198	1
2	Restatements (describe):		2
3	ROUNDING	(2)	3
4	ADJUSTMENT FOR ALLOWANCE OF BAD DEBTS	(96,000)	4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 2,661,196	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	1,307,643	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) OWNERSHIP REDEMPTION	(150,100)	15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 1,157,543	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 3,818,739	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			
	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 13,460,649	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 13,460,649	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	281,664	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 281,664	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***	36,863	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 36,863	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)	\$ 13,779,176	30

2			
	Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,883,716	31
32	Health Care	3,795,859	32
33	General Administration	4,389,667	33
	B. Capital Expense		
34	Ownership	1,105,600	34
	C. Ancillary Expense		
35	Special Cost Centers	1,159,374	35
36	Provider Participation Fee	102,930	36
	D. Other Expenses (specify):		
37	OUT-OF-PERIOD EXPENSES	13,788	37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 12,450,934	40
41	Income before Income Taxes (line 30 minus line 40)**	1,328,242	41
42	Income Taxes	(20,599)	42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 1,307,643	43

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

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

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

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

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	2,121	2,399	\$ 152,415	\$ 63.53	1
2	Assistant Director of Nursing	2,016	2,230	79,983	35.87	2
3	Registered Nurses	40,089	44,896	1,306,251	29.10	3
4	Licensed Practical Nurses	2,927	3,299	84,203	25.52	4
5	CNAs & Orderlies	92,937	99,218	1,089,175	10.98	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	9,401	10,112	175,305	17.34	8
9	Activity Director	1,657	1,976	25,484	12.90	9
10	Activity Assistants	11,061	12,211	132,151	10.82	10
11	Social Service Workers	11,004	12,846	175,134	13.63	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	26,058	28,490	434,520	15.25	15
16	Dishwashers					16
17	Maintenance Workers	3,993	4,497	69,257	15.40	17
18	Housekeepers	20,716	22,637	234,981	10.38	18
19	Laundry	7,150	8,137	105,027	12.91	19
20	Administrator	3,525	3,696	189,081	51.16	20
21	Assistant Administrator	895	951	11,686	12.29	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	14,210	14,999	263,776	17.59	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	1,509	1,669	38,783	23.24	31
32	Other Health Care MDS	4,252	4,703	109,268	23.23	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	255,521	278,966	\$ 4,676,480 *	\$ 16.76	34

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	\$ 9,205	1-3	35
36	Medical Director	Monthly	31,000	9-3	36
37	Medical Records Consultant	24	1,176	10-3	37
38	Nurse Consultant		0	10-3	38
39	Pharmacist Consultant	Monthly	8,632	10-3	39
40	Physical Therapy Consultant		0	10a-3	40
41	Occupational Therapy Consultant		0	10a-3	41
42	Respiratory Therapy Consultant	Monthly	3,840	10a-3	42
43	Speech Therapy Consultant		0	10a-3	43
44	Activity Consultant	Monthly	5,880	11-3	44
45	Social Service Consultant	60	3,374	12-3	45
46	Other(specify) Nursing Consultant	Monthly	23,000	10-3	46
47	Nursing Program Consultant	Monthly	44,000	10-3	47
48					48
49	TOTAL (lines 35 - 48)	84	\$ 130,107		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

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

** See instructions.

STATE OF ILLINOIS

Facility Name & ID NumberPETERSON PARK HEALTH CARE CENTER# 0024463Report Period Beginning:01/01/2011Ending:12/31/2011Page 21

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
ALICIA OSHINSKI	ADMINISTRATOR	0	\$ 84,509
CHAIM SHABAT	ASST ADMIN	0	11,686
RONALD SHABAT	ADMINSTRATIVE	39	104,572
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 200,767

B. Administrative - Other

Description	Amount
SHABAT & ASSOCIATES	\$ 1,457,678
CHAIM RAJCHENBACH	30,000
MENACHEM SHABAT	45,000
LEGACY HEALTHCARE	371,065
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	\$ 1,903,743

C. Professional Services

Vendor/Payee	Type	Amount
		\$
SEE SCHEDULE ATTACHED		149,991
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)		\$ 149,991

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	\$ 189,470
Unemployment Compensation Insurance	30,400
FICA Taxes	349,715
Employee Health Insurance	262,423
Employee Meals	63,948
Illinois Municipal Retirement Fund (IMRF)*	
EMPLOYEE BENEFITS - OTHER	40,361
EMPLOYEE PHYSICAL EXAMS	2,373
PENSION/PROFIT SHARING PLANS	29,586
CHICAGO HEAD TAX	6,480
INSURANCE - EXECUTIVE LIFE	3,721
PAYROLL TAXES - LEGACY	1,872
INSURANCE - EXECUTIVE LIFE VI 21	(3,721)
TOTAL (agree to Schedule V, line 22, col.8)	\$ 976,628

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		\$
TOTAL		\$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	\$
Advertising: Employee Recruitment	0
Health Care Worker Background Check (Indicate # of checks performed)	8,646
Patient Background Checks	0
TRUST/FRANCHISE/CONTRIB/ETC	76,172
MARKETING/ADV/PROMO	47,982
LICENSES/DUES/SUBSCRIPTIONS	20,334
ALLOCATION	495
TRUST/FRANCHISE/CONTRIB/ETC	(76,172)
Less: Public Relations Expense	(0)
Non-allowable advertising	(47,982)
Yellow page advertising	(0)
TOTAL (agree to Sch. V, line 20, col. 8)	\$ 29,475

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	\$
In-State Travel	
	0
Seminar Expense	
	0
MANAGEMENT COMPANY	413
Entertainment Expense	()
(agree to Sch. V, line 24, col. 8)	
TOTAL	\$ 413

* Attach copy of IMRF notifications

**See instructions.

XX. GENERAL INFORMATION:

- (1)

Are nursing employees (RN,LPN,NA) represented by a union?

YES
- (2)

Are there any dues to nursing home associations included on the cost report?

YES

If YES, give association name and amount.

ICLTC=\$14,587, IL. ASSOC.HEALTHCARE\$752
- (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.

\$ 15,177

Line 10-2
- (7)

Have all costs reported on this form been determined using accounting procedures consistent with prior reports?

YES

If NO, attach a complete explanation.
- (8)

Are you presently operating under a sale and leaseback arrangement?

NO

If YES, give effective date of lease.
- (9)

Are you presently operating under a sublease agreement?

YES

X

NO
- (10)

Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)?

YES

NO

If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
- (11)

Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period.

\$ 102,930

This amount is to be recorded on line 42 of Schedule V.
- (12)

Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee?

NO

If YES, attach an explanation of the allocation.

- (13)

Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V?

YES
- (14)

Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B?

NO

For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15)

Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V.

\$ 63,948

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 out of Schedule V?

YES
- (19)

If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report?

YES

Attach invoices and a summary of services for all architect and appraisal fees.