

		FOR BHF USE					

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2012
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2012)

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: 0021238

Facility Name: P. A. Peterson Center For Health

Address: 1311 Parkview Avenue Rockford 61107
Number City Zip Code

County: Winnebago

Telephone Number: (815)399-8832 Fax # (815)399-8342

HFS ID Number:

Date of Initial License for Current Owners: 1941

Type of Ownership:

☒ VOLUNTARY,NON-PROFIT
☒ Charitable Corp.
☐ Trust
IRS Exemption Code 501 C(3)

☐ PROPRIETARY
☐ Individual
☐ Partnership
☐ Corporation
☐ "Sub-S" Corp.
☐ Limited Liability Co.
☐ Trust
☐ Other
☐ GOVERNMENTAL
☐ State
☐ County
☐ Other

In the event there are further questions about this report, please contact:
Name: Steve Lavenda Telephone Number: (847) 236-1111
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 07/01/11 to 06/30/12 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.

Officer or
Administrator
of Provider

(Signed) _____
(Type or Print Name) _____
(Title) _____

Paid
Preparer

(Signed) _____
(Print Name and Title) Steven N. Lavenda, C.P.A.
(Firm Name & Address) Frost, Ruttenberg & Rothblatt, P.C.
111 Pfingsten Road, Suite 300 Deerfield, IL 60015
(Telephone) (847) 236-1111 Fax # (847) 236-1155

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

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

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>129</u>	Skilled (SNF)	<u>129</u>	<u>47,214</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5	<u>29</u>	Sheltered Care (SC)	<u>29</u>	<u>10,614</u>	5
6		ICF/DD 16 or Less			6
7	<u>158</u>	TOTALS	<u>158</u>	<u>57,828</u>	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	<u>12,968</u>	<u>20,233</u>	<u>14,013</u>	<u>47,214</u>	8
9	SNF/PED					9
10	ICF		<u>2,441</u>		<u>2,441</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>12,968</u>	<u>22,674</u>	<u>14,013</u>	<u>49,655</u>	14

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

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

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

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

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

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

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

J. Was the facility purchased or leased after January 1, 1978?
YES ☐ Date _____ NO ☒

K. Was the facility certified for Medicare during the reporting year?
YES ☒ NO ☐ If YES, enter number of beds certified 129 and days of care provided 12,866

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRAUAL ☒ MODIFIED CASH* ☐ CASH* ☐

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number **P. A. Peterson Center For Health** # **0021238** Report Period Beginning: **07/01/11** Ending: **06/30/12**
V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	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			550,729	550,729		550,729	140,751	691,480			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			215,304	215,304		215,304	20,514	235,818			32
33	Real Estate Taxes			182,380	182,380		182,380		182,380			33
34	Rent-Facility & Grounds							66,099	66,099			34
35	Rent-Equipment & Vehicles			8,154	8,154		8,154	1,861	10,015			35
36	Other (specify):*			5,628	5,628		5,628		5,628			36
37	TOTAL Ownership			962,195	962,195		962,195	229,225	1,191,420			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		987,495	1,691,288	2,678,783		2,678,783		2,678,783			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			304,633	304,633		304,633		304,633			42
43	Other (specify):*	36,112			36,112		36,112	(36,112)				43
44	TOTAL Special Cost Centers	36,112	987,495	1,995,921	3,019,528		3,019,528	(36,112)	2,983,416			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	5,162,488	1,689,572	6,649,228	13,501,288		13,501,288	(54,150)	13,447,138			45

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

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	(14,414)	02		4
5	Telephone, TV & Radio in Resident Rooms	(26,490)	05		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	92,589	30		9
10	Interest and Other Investment Income	(23)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax		02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(50,948)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(54,833)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (54,119)		\$	30

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)	(31)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (31)		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (54,150)		37

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

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

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

ID#

0021238

Report Period Beginning:

07/01/11

Ending:

06/30/12

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Additional R&M	\$ 10,598	06	1
2	Marketing Salaries	(36,112)	43	2
3	Capitalized R&M	(17,268)	06	3
4	Health Trust Rebates	(12,051)	21	4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
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	(54,833)		49

ID#

0021238

Report Period Beginning:

07/01/11

Ending:

06/30/12

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

Summary A

06/30/12

[illegible]

VII. RELATED PARTIES

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

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

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

YES

X 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			\$			\$	\$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$			\$	\$ *	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

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

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	17	Salaries & Wages	\$	Lutheran Social Services of Illinois - Management Allocation	100.00%	\$ 425,616	\$ 425,616	15
16	V	22	Empl Benefits & Taxes		Lutheran Social Services of Illinois - Management Allocation	100.00%	83,057	83,057	16
17	V	19	Prof Fees & Contracts		Lutheran Social Services of Illinois - Management Allocation	100.00%	11,906	11,906	17
18	V	21	Supplies, Telephone,		Lutheran Social Services of Illinois - Management Allocation	100.00%	26,502	26,502	18
19	V	34	Rental of Space		Lutheran Social Services of Illinois - Management Allocation	100.00%	63,628	63,628	19
20	V	5	Utilities		Lutheran Social Services of Illinois - Management Allocation	100.00%	2,429	2,429	20
21	V	6	Bldg Repairs & Maintenance		Lutheran Social Services of Illinois - Management Allocation	100.00%	172	172	21
22	V	32	Interest		Lutheran Social Services of Illinois - Management Allocation	100.00%	11,520	11,520	22
23	V	33	Real Estate Taxes		Lutheran Social Services of Illinois - Management Allocation	100.00%			23
24	V	26	Insurance		Lutheran Social Services of Illinois - Management Allocation	100.00%	20,164	20,164	24
25	V	20	Advertising & Promotions		Lutheran Social Services of Illinois - Management Allocation	100.00%	(49)	(49)	25
26	V	25	Transportation		Lutheran Social Services of Illinois - Management Allocation	100.00%	10,383	10,383	26
27	V	35	Car Rental		Lutheran Social Services of Illinois - Management Allocation	100.00%	957	957	27
28	V	24	Conferences & Conventions		Lutheran Social Services of Illinois - Management Allocation	100.00%	4,236	4,236	28
29	V	20	Subscriptions, Dues, Awards		Lutheran Social Services of Illinois - Management Allocation	100.00%	4,160	4,160	29
30	V	6	Furniture & Fixtures		Lutheran Social Services of Illinois - Management Allocation	100.00%			30
31	V	6	Machinery & Equipment		Lutheran Social Services of Illinois - Management Allocation	100.00%			31
32	V	35	Equipment Rental		Lutheran Social Services of Illinois - Management Allocation	100.00%	838	838	32
33	V	6	Equipment Repair & Maint.		Lutheran Social Services of Illinois - Management Allocation	100.00%	19,257	19,257	33
34	V	20	Employee Recruitment		Lutheran Social Services of Illinois - Management Allocation	100.00%			34
35	V	7	Security & Waste Removal		Lutheran Social Services of Illinois - Management Allocation	100.00%	3,139	3,139	35
36	V	21	All Other Miscellaneous		Lutheran Social Services of Illinois - Management Allocation	100.00%	17,980	17,980	36
37	V	30	Depreciation		Lutheran Social Services of Illinois - Management Allocation	100.00%	42,925	42,925	37
38	V	19	Management Fees	748,830	Lutheran Social Services of Illinois - Management Allocation	100.00%		(748,830)	38
39	Total			\$ 748,830			\$ 748,820	\$ * (10)	39

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

VII. RELATED PARTIES (continued)

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

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	17	Salaries & Wages	\$	Lutheran Social Services of Illinois - Human Resource Alloc.	100.00%	\$ 105,171	\$ 105,171	15
16	V	22	Empl Benefits & Taxes		Lutheran Social Services of Illinois - Human Resource Alloc.	100.00%	24,637	24,637	16
17	V	19	Prof Fees & Contracts		Lutheran Social Services of Illinois - Human Resource Alloc.	100.00%	42,925	42,925	17
18	V	21	Supplies, Telephone,		Lutheran Social Services of Illinois - Human Resource Alloc.	100.00%	4,358	4,358	18
19	V	34	Rental of Space		Lutheran Social Services of Illinois - Human Resource Alloc.	100.00%	2,471	2,471	19
20	V	5	Utilities		Lutheran Social Services of Illinois - Human Resource Alloc.	100.00%			20
21	V	6	Bldg Repairs & Maintenance		Lutheran Social Services of Illinois - Human Resource Alloc.	100.00%			21
22	V	32	Interest		Lutheran Social Services of Illinois - Human Resource Alloc.	100.00%	911	911	22
23	V	33	Real Estate Taxes		Lutheran Social Services of Illinois - Human Resource Alloc.	100.00%			23
24	V	26	Insurance		Lutheran Social Services of Illinois - Human Resource Alloc.	100.00%	406	406	24
25	V	20	Advertising & Promotions		Lutheran Social Services of Illinois - Human Resource Alloc.	100.00%			25
26	V	25	Transportation		Lutheran Social Services of Illinois - Human Resource Alloc.	100.00%	873	873	26
27	V	35	Car Rental		Lutheran Social Services of Illinois - Human Resource Alloc.	100.00%	66	66	27
28	V	24	Conferences & Conventions		Lutheran Social Services of Illinois - Human Resource Alloc.	100.00%	4,405	4,405	28
29	V	20	Subscriptions, Dues, Awards		Lutheran Social Services of Illinois - Human Resource Alloc.	100.00%	799	799	29
30	V	6	Furniture & Fixtures		Lutheran Social Services of Illinois - Human Resource Alloc.	100.00%			30
31	V	6	Machinery & Equipment		Lutheran Social Services of Illinois - Human Resource Alloc.	100.00%			31
32	V	35	Equipment Rental		Lutheran Social Services of Illinois - Human Resource Alloc.	100.00%			32
33	V	6	Equipment Repair & Maint.		Lutheran Social Services of Illinois - Human Resource Alloc.	100.00%	1,398	1,398	33
34	V	20	Employee Recruitment		Lutheran Social Services of Illinois - Human Resource Alloc.	100.00%	8,789	8,789	34
35	V	7	Security & Waste Removal		Lutheran Social Services of Illinois - Human Resource Alloc.	100.00%	2	2	35
36	V	21	All Other Miscellaneous		Lutheran Social Services of Illinois - Human Resource Alloc.	100.00%	4,385	4,385	36
37	V	30	Depreciation		Lutheran Social Services of Illinois - Human Resource Alloc.	100.00%	956	956	37
38	V	19	Human Resources Allocations	202,564	Lutheran Social Services of Illinois - Human Resource Alloc.	100.00%		(202,564)	38
39	Total			\$ 202,564			\$ 202,552	\$ * (12)	39

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

VII. RELATED PARTIES (continued)

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

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	17	Salaries & Wages	\$	Lutheran Social Services of Illinois - Network Administration	100.00%	\$ 173,888	\$ 173,888	15
16	V	22	Empl Benefits & Taxes		Lutheran Social Services of Illinois - Network Administration	100.00%	36,017	36,017	16
17	V	19	Prof Fees & Contracts		Lutheran Social Services of Illinois - Network Administration	100.00%	18,665	18,665	17
18	V	21	Supplies, Telephone,		Lutheran Social Services of Illinois - Network Administration	100.00%	2,563	2,563	18
19	V	34	Rental of Space		Lutheran Social Services of Illinois - Network Administration	100.00%			19
20	V	5	Utilities		Lutheran Social Services of Illinois - Network Administration	100.00%			20
21	V	6	Bldg Repairs & Maintenance		Lutheran Social Services of Illinois - Network Administration	100.00%			21
22	V	32	Interest		Lutheran Social Services of Illinois - Network Administration	100.00%	8,106	8,106	22
23	V	33	Real Estate Taxes		Lutheran Social Services of Illinois - Network Administration	100.00%			23
24	V	26	Insurance		Lutheran Social Services of Illinois - Network Administration	100.00%	364	364	24
25	V	20	Advertising & Promotions		Lutheran Social Services of Illinois - Network Administration	100.00%	62	62	25
26	V	25	Transportation		Lutheran Social Services of Illinois - Network Administration	100.00%	2,753	2,753	26
27	V	35	Car Rental		Lutheran Social Services of Illinois - Network Administration	100.00%			27
28	V	24	Conferences & Conventions		Lutheran Social Services of Illinois - Network Administration	100.00%	1,968	1,968	28
29	V	20	Subscriptions, Dues, Awards		Lutheran Social Services of Illinois - Network Administration	100.00%	1,949	1,949	29
30	V	6	Furniture & Fixtures		Lutheran Social Services of Illinois - Network Administration	100.00%			30
31	V	6	Machinery & Equipment		Lutheran Social Services of Illinois - Network Administration	100.00%			31
32	V	35	Equipment Rental		Lutheran Social Services of Illinois - Network Administration	100.00%			32
33	V	6	Equipment Repair & Maint.		Lutheran Social Services of Illinois - Network Administration	100.00%	12	12	33
34	V	20	Employee Recruitment		Lutheran Social Services of Illinois - Network Administration	100.00%			34
35	V	7	Security & Waste Removal		Lutheran Social Services of Illinois - Network Administration	100.00%			35
36	V	21	All Other Miscellaneous		Lutheran Social Services of Illinois - Network Administration	100.00%			36
37	V	30	Depreciation		Lutheran Social Services of Illinois - Network Administration	100.00%	4,281	4,281	37
38	V	19	Service Network Allocations	250,637	Lutheran Social Services of Illinois - Network Administration	100.00%		(250,637)	38
39	Total			\$ 250,637			\$ 250,628	\$ * (9)	39

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

VII. RELATED PARTIES (continued)

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

☐ YES

☐ NO

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

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

☐ YES ☐ NO

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

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

☐ YES

☐ NO

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

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

☐ YES ☐ NO

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

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

☐ YES

☐ NO

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

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

☐ YES ☐ NO

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

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

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	LSSI	100.000%	St. Matthew Center for Health	Park Ridge, IL	VESPER MANAGEMENT	DES PLAINES	MANAGEMENT CO.	1
2					LUTHERAN SOCIAL SERVICES	DES PLAINES	CORPORATE OFFICE	2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

VII. RELATED PARTIES

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

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

VII. RELATED PARTIES (continued)

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

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

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

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

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

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

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

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	17	Salaries & Wages	Non-Capital Direct Costs	8,644,385	25	\$ 303,617	\$ 303,617	4,950,818	\$ 173,888	1
2	22	Empl Benefits & Taxes		8,644,385	25	62,887		4,950,818	36,017	2
3	19	Prof Fees & Contracts		8,644,385	25	32,590		4,950,818	18,665	3
4	21	Supplies, Telephone,		8,644,385	25	4,476		4,950,818	2,563	4
5		Postage, Out. Printing		8,644,385	25			4,950,818		5
6	34	Rental of Space		8,644,385	25			4,950,818		6
7	5	Utilities		8,644,385	25			4,950,818		7
8	6	Bldg Repairs & Maintenance		8,644,385	25			4,950,818		8
9	32	Interest		8,644,385	25	14,153		4,950,818	8,106	9
10	33	Real Estate Taxes		8,644,385	25			4,950,818		10
11	26	Insurance		8,644,385	25	636		4,950,818	364	11
12	20	Advertising & Promotions		8,644,385	25	108		4,950,818	62	12
13	25	Transportation		8,644,385	25	4,807		4,950,818	2,753	13
14	35	Car Rental		8,644,385	25			4,950,818		14
15	24	Conferences & Conventions		8,644,385	25	3,436		4,950,818	1,968	15
16	20	Subscriptions, Dues, Awards		8,644,385	25	3,403		4,950,818	1,949	16
17	6	Furniture & Fixtures		8,644,385	25			4,950,818		17
18	6	Machinery & Equipment		8,644,385	25			4,950,818		18
19	35	Equipment Rental		8,644,385	25			4,950,818		19
20	6	Equipment Repair & Maint.		8,644,385	25	21		4,950,818	12	20
21	20	Employee Recruitment		8,644,385	25			4,950,818		21
22	7	Security & Waste Removal		8,644,385	25			4,950,818		22
23	21	All Other Miscellaneous		8,644,385	25			4,950,818		23
24	30	Depreciation		8,644,385	25	7,474		4,950,818	4,281	24
25	TOTALS					\$ 437,608	\$ 303,617		\$ 250,628	25

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

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

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

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

()

()

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

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

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

()

()

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

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

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

()

()

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

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

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

B. Real Estate Taxes

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

		FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2011	\$		13
14	PLUS APPEAL COST FROM LINE 5	\$		14
15	LESS REFUND FROM LINE 6	\$		15
16	AMOUNT TO USE FOR RATE CALCULATION	\$		16

- NOTES:
1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.

2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

SEE ACCOUNTANTS' COMPILATION REPORT

FACILITY NAME	<u>P. A. Peterson Center For Health</u>	COUNTY	<u>Winnebago</u>
---------------	---	--------	------------------

CONTACT PERSON REGARDING THIS REPORT

A. Summary of Real Estate Tax Cost

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

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

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services?

YES	X	NO
-----	---	----

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

C. Tax Bills

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

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

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates RE: 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAMEP. A. Peterson Center For HealthCOUNTYWinnebago

FACILITY IDPH LICENSE NUMBER0021238

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE ()FAX #: ()

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2000 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 2000.

(A)	(B)	(C)	(D)
Tax Index Number	Property Description	Total Tax	Tax Applicable to Nursing Home
1.		\$	\$
2.		\$	\$
3.		\$	\$
4.		\$	\$
5.		\$	\$
6.		\$	\$
7.		\$	\$
8.		\$	\$
9.		\$	\$
10.		\$	\$
TOTALS		\$	\$

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 NO

If YES, attach an explanation & 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 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 110,000

B. General Construction Type: Exterior Masonry Frame Steel Grids Number of Stories 3

C. Does the Operating Entity?

☒ (a) Own the Facility

☐ (b) Rent from a Related Organization.

☐ (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity?

☒ (a) Own the Equipment

☒ (b) Rent equipment from a Related Organization.

☒ (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

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

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?

☐ YES

☒ NO

If so, please complete the following:

1. Total Amount Incurred:

2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization:

4. Dates Incurred:

Nature of Costs:

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

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Facility	192,020	1985	\$ 8,455	1
2					2
3	TOTALS	192,020		\$ 8,455	3

SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)

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

	1	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	158		1942	1942	\$ 95,858	\$	40	\$	\$	\$ 95,858	4
5			1979	1979	5,596,922		40	139,923	139,923	4,616,877	5
6											6
7											7
8											8
	Improvement Type**										
9	Various		1969		5,300		20			5,300	9
10	Various		1975		9,226		20			9,226	10
11	Various		1977		10,074		20			10,074	11
12	Various		1980		71,947		20	144	144	71,912	12
13	Various		1981		7,309		20			7,309	13
14	Various		1982		6,151		20			6,151	14
15	Various		1983		30,936		20			30,936	15
16	Various		1984		15,554		20			15,554	16
17	Various		1985		4,850		20			4,850	17
18	Various		1986		21,640		20			21,640	18
19	Various		1988		4,414		20			4,414	19
20	Various		1989		71,006		20			71,006	20
21	Various		1990		103,287		20	5,031	5,031	99,326	21
22	Various		1991		64,328		20			64,328	22
23	Various		1992		20,528		20			20,528	23
24	Various		1993		4,296		20			4,296	24
25	Various		1994		86,971		20			86,971	25
26	Various		1995		767,445		20	30,034	30,034	601,818	26
27	Various		1996		12,220		20			12,220	27
28	Various		1997		2,685		20			2,685	28
29	Various		1998		149,521		20	3,864	3,864	129,805	29
30	Various		1999		17,200		20			17,201	30
31	Various		2000		63,500		20	3,175	3,175	35,116	31
32	Various		2001		109,787		20	5,489	5,489	74,842	32
33	Various		2002		79,186		20	3,959	3,959	55,191	33
34	Various		2003		121,363		20	7,685	7,685	90,471	34
35	Various		2004		10,088		20	504	504	4,294	35
36	Various		2005		1,697,455		20	84,873		595,961	36

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

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

XI. OWNERSHIP COSTS (continued)

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

1		3	4	5	6	7	8	9	
Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	Various	2006	\$ 371,882	\$	20	\$ 18,594	\$ 18,594	\$ 126,169	37
38	Various	2007	1,287,268		20	64,363	64,363	398,864	38
39	Various	2008	249,406		20	12,244	12,244	64,411	39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67	Related Building Company (Pages 12F & 12G)								67
68	Related Party Allocations (Pages 12H & 12I)			48,162			(48,162)		68
69	Financial Statement Depreciation			550,729			(550,729)		69
70	TOTAL (lines 4 thru 69)		\$ 11,169,603	\$ 598,891		\$ 379,883	\$ (303,881)	\$ 7,455,604	70

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

0021238

Report Period Beginning:

07/01/11

Ending:

06/30/12

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1		3	4	5	6	7	8	9	
Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$11,872,113	\$598,891		\$415,391	\$(183,500)	\$7,540,429	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$11,872,113	\$598,891		\$415,391	\$(183,500)	\$7,540,429	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1		3	4	5	6	7	8	9	
Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		\$11,872,113	\$598,891		\$415,391	\$(183,500)	\$7,540,429	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$11,872,113	\$598,891		\$415,391	\$(183,500)	\$7,540,429	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1	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	Building Company Information								1
2	Buildings:								2
3									3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
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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

XI. OWNERSHIP COSTS (continued)

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Related Party Information		\$	\$		\$	\$	\$	1
2	Buildings:								2
3									3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9									9
10	LSSI Allocation (Schedule VIII)			48,162			(48,162)		10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34									34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1		3	4	5	6	7	8	9	
Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Related Party Information Continued								1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (12H & 12I lines 1 thru 33)		\$	\$ 48,162		\$	\$ (48,162)	\$	34

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$2,741,044	\$	\$268,921	\$268,921	10	\$2,285,827	71
72	Current Year Purchases	40,095		4,009	4,009	10	4,009	72
73	Fully Depreciated Assets	741,510				10	741,510	73
74								74
75	TOTALS	\$3,522,649	\$	\$272,931	\$272,931		\$3,031,346	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76		2006 Chevy Turtle Top Bus	2006	\$96,576	\$	\$		5	\$96,576	76
77		94 Chevrolet Pickup	2011	15,788		3,158	3,158	5	3,158	77
78										78
79										79
80	TOTALS			\$112,364	\$	\$3,158	\$3,158		\$99,733	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$15,515,581	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$598,891	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$691,480	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$92,589	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$10,671,508	85

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

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	Renovation of Assisted Living - 2001	\$880	\$	\$	86
87	Renovation of Assisted Living - 2001	4,363			87
88	Renovation of Assisted Living - 2001	2,129			88
89	95 Improvement CORF - 1995	30,219			89
90	Dodge Van - 1997	17,032			90
91	TOTALS	\$54,623	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92	Architect Services	\$24,686	92
93			93
94			94
95		\$24,686	95

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions.
- ☐ YES☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5	Allocate LSSI (Schedule VIII)				66,099			5
6								6
7	TOTAL				\$ 66,099			7

**

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

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

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

15. Is Movable equipment rental included in building rental?
- ☐ YES☐ NO
16. Rental Amount for movable equipment: \$ 7,139
- Description: See Attached Schedule

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Facility		\$	\$ 1,853	17
18	Allocate LSSI (Schedule VIII)			1,023	18
19					19
20					20
21	TOTAL		\$	\$ 2,876	21

10. Effective dates of current rental agreement:

Beginning

Ending

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

	Fiscal Year Ending	Annual Rent
12.	/2013	\$
13.	/2014	\$
14.	/2015	\$

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

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

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

☐

☐

B. EXPENSES

C. CONTRACTUAL INCOME

D. NUMBER OF CNAs TRAINED

ALLOCATION OF COSTS (d)

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

		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)	\$			

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

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.

(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.

(c) For in-house training programs only. Do not include fringe benefits.

(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.

(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

SEE ACCOUNTANTS' COMPILATION REPORT

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

		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 - 03	hrs	\$		\$ 569,862	\$		\$ 569,862	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			119,394			119,394	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			991,553			991,553	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 02	# of prescrpts				501,480		501,480	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): See Supplemental					10,479	486,015		496,494	13
14	TOTAL			\$		\$ 1,691,288	\$ 987,495		\$ 2,678,783	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

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

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

XVI. STATEMENT OF CHANGES IN EQUITY

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

* This must agree with page 17, line 47.

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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

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

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

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

* This must agree with page 4, line 45, column 4.
** Does this agree with taxable income (loss) per Federal Income Tax Return? N/A If not, please attach a reconciliation.
*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

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

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

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,618	1,959	\$ 78,102	\$ 39.87	1
2	Assistant Director of Nursing	1,670	1,849	69,541	37.61	2
3	Registered Nurses	44,121	46,704	1,283,119	27.47	3
4	Licensed Practical Nurses	35,089	36,486	797,476	21.86	4
5	CNAs & Orderlies	101,390	105,913	1,216,878	11.49	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	162	173	2,778	16.06	9
10	Activity Assistants	14,966	20,710	190,514	9.20	10
11	Social Service Workers	8,492	9,439	138,240	14.65	11
12	Dietician					12
13	Food Service Supervisor	4,351	4,591	63,484	13.83	13
14	Head Cook	7,747	7,965	81,308	10.21	14
15	Cook Helpers/Assistants	33,226	33,871	295,425	8.72	15
16	Dishwashers					16
17	Maintenance Workers	7,384	7,865	122,866	15.62	17
18	Housekeepers	20,085	21,324	188,721	8.85	18
19	Laundry	593	632	5,392	8.53	19
20	Administrator	1,808	2,025	92,348	45.60	20
21	Assistant Administrator	1,823	2,025	62,567	30.90	21
22	Other Administrative	667	838	21,994	26.25	22
23	Office Manager	3,450	3,936	85,427	21.70	23
24	Clerical	18,446	19,373	261,181	13.48	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) See Supplemental	4,887	5,478	105,127	19.19	33
34	TOTAL (lines 1 - 33)	311,975	333,156	\$ 5,162,488 *	\$ 15.50	34

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	As Needed	\$ 123,276	01-03	35
36	Medical Director	As Needed	16,250	09-03	36
37	Medical Records Consultant	As Needed	2,479	10-03	37
38	Nurse Consultant	As Needed	18,328	10-03	38
39	Pharmacist Consultant	As Needed	5,995	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	As Needed	7,938	12-03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 174,266		49

C. CONTRACT NURSES

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

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

** See instructions.

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

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1	N/A		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

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XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. LSN-\$4,460
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? _____
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 10 Yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 28,795 Line 10-02
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? _____ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 304,633
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.

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- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 14,414
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? None
d. Have vehicle usage logs been maintained? Yes
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? Yes
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ _____
- (17) Has an audit been performed by an independent certified public accounting firm? Yes
Firm Name: Baker Tilly Virchow Krause, LLP
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? Yes
Attach invoices and a summary of services for all architect and appraisal fees.