

		FOR OHF USE					

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**2004
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2004)**

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.

<p>I. IDPH Facility ID Number: <u>0045492</u></p> <p>Facility Name: <u>EAST PEORIA GARDENS HEALTHCARE CENTER</u></p> <p>Address: <u>1910 SPRINGFIELD ROAD</u> <u>EAST PEORIA</u> <u>62301</u> Number City Zip Code</p> <p>County: <u>TAZEWELL</u></p> <p>Telephone Number: <u>(847) 694-1435</u> Fax # <u>(847) 694-1475</u></p> <p>IDPA ID Number: <u>36-4420686</u></p> <p>Date of Initial License for Current Owners: <u>10/01/01</u></p> <p>Type of Ownership:</p> <table border="0"> <tr> <td><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input checked="" type="checkbox"/> PROPRIETARY</td> <td><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td>IRS Exemption Code _____</td> <td><input type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> "Sub-S" Corp.</td> <td></td> </tr> <tr> <td></td> <td><input checked="" type="checkbox"/> Limited Liability Co.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other _____</td> <td></td> </tr> </table> <p>In the event there are further questions about this report, please contact: Name: <u>BOB KAGDA</u> Telephone Number: <u>(847) 675-3585</u></p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County	IRS Exemption Code _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input type="checkbox"/> "Sub-S" Corp.			<input checked="" type="checkbox"/> Limited Liability Co.			<input type="checkbox"/> Trust			<input type="checkbox"/> Other _____		<p>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/2004</u> to <u>12/31/2004</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="1"> <tr> <td data-bbox="1473 751 1661 954">Officer or Administrator of Provider</td> <td data-bbox="1661 751 2553 954">(Signed) _____ (Type or Print Name) <u>SHERWIN I. RAY</u> (Title) <u>PRESIDENT</u></td> </tr> <tr> <td data-bbox="1473 954 1661 1239">Paid Preparer</td> <td data-bbox="1661 954 2553 1239">(Signed) <u>(SEE ATTACHED ACCOUNTANTS' REPORT)</u> (Date) _____ (Print Name and Title) <u>BOB KAGDA</u> <u>PARTNER</u> (Firm Name & Address) <u>KRUPNICK BOKOR KAGDA & BROOKS, LTD</u> <u>3750 W DEVON AVE, LINCOLNWOOD, IL 60712-1124</u> (Telephone) <u>(847) 675-3585</u> Fax # <u>(847) 675-5777</u></td> </tr> </table> <p align="right">MAIL TO: OFFICE OF HEALTH FINANCE ILLINOIS DEPARTMENT OF PUBLIC AID 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630</p>	Officer or Administrator of Provider	(Signed) _____ (Type or Print Name) <u>SHERWIN I. RAY</u> (Title) <u>PRESIDENT</u>	Paid Preparer	(Signed) <u>(SEE ATTACHED ACCOUNTANTS' REPORT)</u> (Date) _____ (Print Name and Title) <u>BOB KAGDA</u> <u>PARTNER</u> (Firm Name & Address) <u>KRUPNICK BOKOR KAGDA & BROOKS, LTD</u> <u>3750 W DEVON AVE, LINCOLNWOOD, IL 60712-1124</u> (Telephone) <u>(847) 675-3585</u> Fax # <u>(847) 675-5777</u>
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Facility Name & ID Number EAST PEORIA GARDENS HEALTHCARE CENTER

0045492 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

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 06/10/04

	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		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3	120	Intermediate (ICF)	103	40,435	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	120	TOTALS	103	40,435	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF			39	39	8
9	SNF/PED					9
10	ICF	24,336	2,568		26,904	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	24,336	2,568	39	26,943	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 66.63%

D. How many bed-hold days during this year were paid by Public Aid? 0 (Do not include bed-hold days in Section B.)

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

NONE

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

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

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

I. On what date did you start providing long term care at this location?
Date started 10/01/01

J. Was the facility purchased or leased after January 1, 1978?
YES Date 10/01/01 NO

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified and days of care provided 39

Medicare Intermediary ADMIMISTAR

IV. ACCOUNTING BASIS

ACCRAUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/2004 Fiscal Year: 12/31/2004

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

Facility Name & ID Number **EAST PEORIA GARDENS HEALTHCARE** # **0045492** Report Period Beginning: **01/01/2004** Ending: **12/31/2004**

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 OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	116,602	8,259	5,222	130,083		130,083		130,083		1
2	Food Purchase		104,485		104,485	(12,407)	92,078	(498)	91,580		2
3	Housekeeping	72,718	13,546		86,264		86,264		86,264		3
4	Laundry	37,323	11,176	277	48,776		48,776		48,776		4
5	Heat and Other Utilities			73,555	73,555		73,555	373	73,928		5
6	Maintenance	31,558	28,559	22,535	82,652		82,652	3,802	86,454		6
7	Other (specify):*			8,271	8,271		8,271	196	8,467		7
8	TOTAL General Services	258,201	166,025	109,860	534,086	(12,407)	521,679	3,873	525,552		8
	B. Health Care and Programs										
9	Medical Director			10,500	10,500		10,500		10,500		9
10	Nursing and Medical Records	674,710	21,342	630	696,682		696,682	14,353	711,035		10
10a	Therapy	21,276	1,727	17,560	40,563		40,563	(13,755)	26,808		10a
11	Activities	36,678	250		36,928		36,928		36,928		11
12	Social Services	46,830		2,049	48,879		48,879		48,879		12
13	Nurse Aide Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	779,494	23,319	30,739	833,552		833,552	598	834,150		16
	C. General Administration										
17	Administrative	45,631		50,000	95,631		95,631	(11,521)	84,110		17
18	Directors Fees										18
19	Professional Services			58,756	58,756		58,756	(8,324)	50,432		19
20	Dues, Fees, Subscriptions & Promotions			14,734	14,734		14,734	(7,154)	7,580		20
21	Clerical & General Office Expenses	79,701	6,972	67,850	154,523		154,523	4,319	158,842		21
22	Employee Benefits & Payroll Taxes			179,244	179,244	12,407	191,651		191,651		22
23	Inservice Training & Education			75	75		75	690	765		23
24	Travel and Seminar			502	502		502	227	729		24
25	Other Admin. Staff Transportation			1,152	1,152		1,152	2,293	3,445		25
26	Insurance-Prop.Liab.Malpractice			86,571	86,571		86,571	1,443	88,014		26
27	Other (specify):*							25,437	25,437		27
28	TOTAL General Administration	125,332	6,972	458,884	591,188	12,407	603,595	7,410	611,005		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,163,027	196,316	599,483	1,958,826		1,958,826	11,881	1,970,707		29

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

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

V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE	SCHED REF	TOTAL
1	DIETARY	
	DIETITIAN CONSULTANT XVIII B 35-2	5,222
	REPAIRS & MAINTENANCE	0
		0
		5,222
3	HOUSEKEEPING	
		0
		0
		0
4	LAUNDRY	
	EQUIPMENT REPAIRS & MAINTENANCE	277
		0
		277
5	HEAT & OTHER UTILITIES	
	GAS HEAT	28,761
	ELECTRICITY	19,887
	WATER	20,634
	CABLE TV - LOBBY	4,273
		0
		73,555
6	MAINTENANCE	
	GROUNDS MAINTENANCE	2,560
	PAINTING & DECORATING	824
	BUILDING REPAIRS	0
	MAINTENANCE TRAVEL	0
	EQUIPMENT MAINTENANCE & REPAIR	8,513
	ELEVATOR MAINTENANCE & REPAIR	0
	OUTSIDE LABOR	0
	EXTERMINATING SERVICE	1,291
	FIRE SERVICE	9,347
		0
		0
		0
		22,535
7	OTHER	
	SCAVENGER	8,271
	SECURITY SERVICE	0
		8,271
9	MEDICAL DIRECTOR	
	MEDICAL DIRECTOR FEES XVIII B 36-2	10,500
		10,500

LINE	SCHED REF	TOTAL
10	NURSING	
	CONTRACT NURSING XVIII C 53-2	0
	LABORATORY & XRAY EXPENSE	0
	PURCHASED SERVICES	0
	PSYCHO-SOCIAL CONSULTANT XVIII B ___-2	0
	RESTORATIVE NURSING CONSULTANT XVIII B 38-2	0
	MEDICAL RECORDS CONSULTANT XVIII B 37-2	0
	PHARMACY CONSULTANT XVIII B 39-2	630
	UTILIZATION REVIEW FEES XVIII B ___-2	0
	PHYSICIANS XVIII B ___-2	0
	PSYCHIATRIC XVIII B ___-2	0
	RN CONSULTANT XVIII B 38-2	0
		0
		0
		630
10a	THERAPY	
	PHYSICAL THERAPY SERVICES	207
	THERAPY CONTRACT SERVICES	6,094
	OCCUPATIONAL THERAPY SERVICES	459
	REHABILITATION CONSULTANT XVIII B ___-2	0
	PHYSICAL THERAPY CONSULTANT XVIII B 40-2	5,400
	OCCUPATIONAL THERAPY CONSULTA XVIII B 41-2	5,400
	RESPIRATORY THERAPY CONSULTAN XVIII B 42-2	0
	SPEECH THERAPY CONSULTANT XVIII B 43-2	0
		17,560
11	ACTIVITIES	
	CABLE TV - PATIENT ROOMS	0
	ACTIVITY REHAB CONSULTANT XVIII B 44-2	0
		0
		0
12	SOCIAL SERVICES	
	SOCIAL REHABILITATION SERVICES	0
	SOCIAL REHABILITATION CONSULTAN XVIII B 45-2	0
	SOCIAL WORKER XVIII B 45-2	2,049
		0
		2,049
13	NURSE AIDE TRAINING	
	NURSE AIDE TRAINING COSTS XIII	0
		0

V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE	SCHED REF	TOTAL
14	PROGRAM TRANSPORTATION	
	PATIENT TRANSPORTATION	0
17	ADMINISTRATIVE	
	MANAGEMENT FEES XIX B	50,000
18	DIRECTORS FEES	0
19	PROFESSIONAL SERVICES	
	DATA PROCESSING XIX C	9,964
	ADMINISTRATIVE CONSULTANTS XIX C	0
	PROFESSIONAL FEES XIX C	48,792
		0
		58,756
20	FEES,SUBSCRIPTIONS,PROMOTIONS	
	ENTERTAINMENT & MARKETING VI 19 XIX F	0
	ADV & PROMO-NON PATIENT RELATED VI 25 XIX F	2,613
	EMPLOYEE WANT ADS XIX F	4,187
	CONTRIBUTIONS VI 20 XIX F	50
	DUES & SUBSCRIPTIONS XIX F	0
	LICENSES & PERMITS XIX F	1,673
	PUBLIC RELATIONS-PATIENT RELATED XIX F	0
	ADVERTISING-YELLOW PAGES VI 28 XIX F	6,176
	TRUST FEES / FRANCHISE TAX / ETC VI 17 XIX F	0
	CONTRIBUTIONS - POLITICAL VI 20 XIX F	0
	HEALTH CARE WORKER BACKGROUND CHEC XIX F	35
		14,734
21	CLERICAL & GENERAL OFFICE EXPENSES	
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)	6,686
	EQUIPMENT REPAIR & MAINTENANCE	654
	OUTSIDE CLERICAL SERVICES	50,000
	PENALTIES / OVERDRAFT CHARGES VI 18	140
	HOME OFFICE EXPENSE	0
	THEFT & DAMAGE LOSS	0
	TELEPHONE	8,807
	MESSENGER SERVICE	1,563
		0
		67,850

LINE	SCHED REF	TOTAL
22	EMPLOYEE BENEFITS & PAYROLL TAXES	
	FICA TAXES XIX D	87,740
	UNEMPLOYMENT COMPENSATION XIX D	43,943
	WORKERS COMPENSATION INSURANCE XIX D	31,543
	HOSPITALIZATION INSURANCE XIX D	14,518
	EMPLOYEE BENEFITS - OTHER XIX D	1,500
	EMPLOYEE PHYSICAL EXAMS XIX D	0
	INSURANCE - EXECUTIVE LIFE VI 21/XIX D	0
	PENSION/PROFIT SHARING PLANS XIX D	0
	CHICAGO HEAD TAX XIX D	0
		179,244
23	INSERVICE TRAINING & EDUCATION	
	EDUCATION & SEMINARS	75
		75
24	TRAVEL & SEMINARS	
	EDUCATION & SEMINARS XIX G	0
	TRAVEL XIX G	502
		0
		0
		502
25	ADMIN. STAFF TRANSPORTATION	
	TRANSPORTATION - STAFF	1,152
		1,152
26	INSURANCE - PROP. LIAB & MALPRACTICE	
	GENERAL INSURANCE	86,571
		86,571
27	OTHER	
	BAD DEBTS VI 24	0
		0

GRAND TOTAL COLUMN 3 OTHER

599,483

EAST PEORIA GARDENS HEALTHCARE CENTER
 EMPLOYEE MEAL RECLASSIFICATION (PAGE 3 SCHEDULE V COLUMN 5 LINES 2 AND 22)
 12/31/2004

TOTAL FOOD PURCHASE	104,485	PATIENT MEALS	80829
LESS SALES TAX	(498)	ADD EMPLOYEE MEALS	10980
	-----		-----
NET FOOD	103,987	TOTAL MEALS/YEAR	91809
TOTAL PATIENT CENSUS	26,943	NET FOOD	103987
TIME 3 MEALS PER DAY	3	DIVIDE TOTAL MEALS/YEAR	91809

TOTAL PATIENT MEALS	80829	COST PER MEAL	1.13
		TIME EMPLOYEE MEALS	10980
ADD # EMPLOYEE MEALS/DAY	30		-----
TIME # DAYS	366	EMPLOYEE MEAL RECLASSIFICATION	12407
	-----		=====
TOTAL EMPLOYEE MEALS	10980		

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			36,057	36,057		36,057	11,527	47,584			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			52,382	52,382		52,382	15,883	68,265			32
33	Real Estate Taxes			24,366	24,366		24,366		24,366			33
34	Rent-Facility & Grounds							3,396	3,396			34
35	Rent-Equipment & Vehicles			43,495	43,495		43,495	(29,249)	14,246			35
36	Other (specify):*											36
37	TOTAL Ownership			156,300	156,300		156,300	1,557	157,857			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		512	3,552	4,064		4,064	(2,970)	1,094			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			60,653	60,653		60,653		60,653			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		512	64,205	64,717		64,717	(2,970)	61,747			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,163,027	196,828	819,988	2,179,843		2,179,843	10,468	2,190,311			45

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

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(15,574)	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(498)	2		13
14	Non-Care Related Interest		32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees		20		17
18	Fines and Penalties	(140)	21		18
19	Entertainment		20		19
20	Contributions	(50)	20		20
21	Owner or Key-Man Insurance		22		21
22	Special Legal Fees & Legal Retainers	(10,450)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt		27		24
25	Fund Raising, Advertising and Promotional	(2,613)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(6,176)	20		28
29	Other-Attach Schedule	(3,231)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (38,732)		\$	30

OHF 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	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	49,200		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 49,200		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ 10,468		37

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

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

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

ID# 0045492

Report Period Beginning: 01/01/2004

Ending: 12/31/2004

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	DEFERRED MAINTENANCE	\$ 0	6	1
2	MARKETING SALARY	(3,231)	21	2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
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39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(3,231)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number EAST PEORIA GARDENS HEALTHCARE CENTER# 0045492

Report Period Beginning:

01/01/2004

Ending:

12/31/2004

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(498)	0	0	0	0	0	0	0	0	0	0	(498)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	373	0	0	0	0	0	0	0	0	373	5
6	Maintenance	0	0	3,802	0	0	0	0	0	0	0	0	3,802	6
7	Other (specify):*	0	0	196	0	0	0	0	0	0	0	0	196	7
8	TOTAL General Services	(498)	0	4,371	0	3,873	8							
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	14,353	0	0	0	0	0	0	0	0	14,353	10
10a	Therapy	0	(15,651)	1,896	0	0	0	0	0	0	0	0	(13,755)	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	(15,651)	16,249	0	598	16							
	C. General Administration													
17	Administrative	0	(50,000)	38,479	0	0	0	0	0	0	0	0	(11,521)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(10,450)	0	2,126	0	0	0	0	0	0	0	0	(8,324)	19
20	Fees, Subscriptions & Promotions	(8,839)	0	1,685	0	0	0	0	0	0	0	0	(7,154)	20
21	Clerical & General Office Expenses	(3,371)	(50,000)	57,690	0	0	0	0	0	0	0	0	4,319	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	690	0	0	0	0	0	0	0	0	690	23
24	Travel and Seminar	0	0	227	0	0	0	0	0	0	0	0	227	24
25	Other Admin. Staff Transportation	0	0	2,293	0	0	0	0	0	0	0	0	2,293	25
26	Insurance-Prop.Liab.Malpractice	0	0	1,443	0	0	0	0	0	0	0	0	1,443	26
27	Other (specify):*	0	0	25,437	0	0	0	0	0	0	0	0	25,437	27
28	TOTAL General Administration	(22,660)	(100,000)	130,070	0	7,410	28							
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(23,158)	(115,651)	150,690	0	11,881	29							

STATE OF ILLINOIS

Summary B

Facility Name & ID Number EAST PEORIA GARDENS HEALTHCARE CENTER# 0045492

Report Period Beginning:

01/01/2004 Ending:12/31/2004

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
30	Depreciation	(15,574)	21,565	5,536	0	0	0	0	0	0	0	0	11,527	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	15,883	0	0	0	0	0	0	0	0	15,883	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	3,396	0	0	0	0	0	0	0	0	3,396	34
35	Rent-Equipment & Vehicles	0	(32,933)	3,684	0	0	0	0	0	0	0	0	(29,249)	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(15,574)	(11,368)	28,499	0	1,557	37							
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	(2,970)	0	0	0	0	0	0	0	0	0	(2,970)	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	(2,970)	0	0	0	0	0	0	0	0	0	(2,970)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(38,732)	(129,989)	179,189	0	10,468	45							

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
SCHEDULE ATTACHED		SCHEDULE ATTACHED		CAREPLUS MGMT	NILES	
				EAST PEORIA GARDENS LLC		
					NILES	
				CAREPLUS REHABILITATIVE SERVICES		
					NILES	

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	30 DEPRECIATION	\$	EAST PEORIA GARDENS REALTY LLC		\$ 21,565	\$ 21,565	1
2	V							2
3	V	17 MANAGEMENT FEE	50,000	CAREPLUS MANAGEMENT INC			(50,000)	3
4	V	21 CLERICAL FEES	50,000	" " "			(50,000)	4
5	V							5
6	V	39 THERAPY SERVICES	3,551	CAREPLUS REHABILITATIVE SERVICES		581	(2,970)	6
7	V	10A THERAPY SERVICES	17,559	" " "		1,908	(15,651)	7
8	V	35 EQUIPMENT RENT	32,933	" " "			(32,933)	8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 154,043			\$ 24,054	\$ * (129,989)	14

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	1	DIETARY SALARIES	\$	CAREPLUS MANAGEMENT INC	100.00%	\$		15
16	V	5	ELECTRICITY		" " "		373	373	16
17	V	6	MAINT & REPAIRS		" " "		13	13	17
18	V	6	MAINTENANCE SALARIES		" " "		3,789	3,789	18
19	V	7	SECURITY		" " "		196	196	19
20	V	10	NURSING SALARIES		" " "		14,353	14,353	20
21	V	10a	THERAPY SALARIES		" " "		1,896	1,896	21
22	V	17	ADMIN SALARIES		" " "		38,479	38,479	22
23	V	19	PROFESSIONAL FEES		" " "		2,126	2,126	23
24	V	20	ADVERTISING		" " "		1,685	1,685	24
25	V	21	OFFICE EXPENSE		" " "		18,661	18,661	25
26	V	21	OFFICE SALARIES		" " "		39,029	39,029	26
27	V	23	SEMINARS		" " "		690	690	27
28	V	24	TRAVEL		" " "		227	227	28
29	V	25	TRANSPORATION		" " "		2,293	2,293	29
30	V	26	INSURANCE		" " "		1,443	1,443	30
31	V	27	EMPLOYEE BENEFITS		" " "		25,437	25,437	31
32	V	30	DEPRECIATION		" " "		5,536	5,536	32
33	V	32	INTEREST		" " "		15,883	15,883	33
34	V	34	OFFICE RENT		" " "		3,396	3,396	34
35	V	35	EQUIPMENT RENT		" " "		3,684	3,684	35
36	V								36
37	V								37
38	V								38
39	Total		\$				\$ 179,189	\$ * 179,189	39

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

Facility Name & ID Number EAST PEORIA GARDENS HEALTHCARE # 0045492 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

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	SHERWIN I RAY	ADMIN CONSULT			SEE ATTACHED			SALARY	\$ 8,811	17-7	1
2	JAKOB BAKST	DIR OPERATIONS			SCHEDULES			SALARY	8,811	17-7	2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 17,622		13

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

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

Facility Name & ID Number EAST PEORIA GARDENS HEALTHCARE CENTER # 0045492 Report Period Beginning: 01/01/2004 Ending: 2/31/2004

VIII. ALLOCATION OF INDIRECT COSTS

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

Name of Related Organization CAREPLUS MANAGEMENT INC
 Street Address 8320 SKOKIE BLVD
 City / State / Zip Code SKOKIE, IL 60077
 Phone Number (847)329-1555
 Fax Number (847) 329-9555

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	1	DIETARY SALARIES	PATIENT DAYS	565,586	13	\$ 26,990	\$ 26,990	\$ 0	1
2	5	ELECTRICITY	PATIENT DAYS	565,586	13	7,834	26,943	373	2
3	6	MAINT & REPAIRS	PATIENT DAYS	565,586	13	275	26,943	13	3
4	6	MAINTENANCE SALARIES	PATIENT DAYS	565,586	13	79,548	26,943	3,789	4
5	7	SECURITY	PATIENT DAYS	565,586	13	4,112	26,943	196	5
6	10	NURSING SALARIES	PATIENT DAYS	565,586	13	301,295	26,943	14,353	6
7	10a	THERAPY SALARIES	PATIENT DAYS	565,586	13	39,798	26,943	1,896	7
8	17	ADMIN SALARIES	PATIENT DAYS	565,586	13	807,745	26,943	38,479	8
9	19	PROFESSIONAL FEES	PATIENT DAYS	565,586	13	44,637	26,943	2,126	9
10	20	ADVERTISING	PATIENT DAYS	565,586	13	35,362	26,943	1,685	10
11	21	OFFICE EXPENSE	PATIENT DAYS	565,586	13	391,736	26,943	18,661	11
12	21	OFFICE SALARIES	PATIENT DAYS	565,586	13	819,289	26,943	39,029	12
13	23	SEMINARS	PATIENT DAYS	565,586	13	14,490	26,943	690	13
14	24	TRAVEL	PATIENT DAYS	565,586	13	4,769	26,943	227	14
15	25	TRANSPORATION	PATIENT DAYS	565,586	13	48,136	26,943	2,293	15
16	26	INSURANCE	PATIENT DAYS	565,586	13	30,286	26,943	1,443	16
17	27	EMPLOYEE BENEFITS	PATIENT DAYS	565,586	13	533,964	26,943	25,437	17
18	30	DEPRECIATION	PATIENT DAYS	565,586	13	116,219	26,943	5,536	18
19	32	INTEREST	PATIENT DAYS	565,586	13	333,416	26,943	15,883	19
20	34	OFFICE RENT	PATIENT DAYS	565,586	13	71,288	26,943	3,396	20
21	35	EQUIPMENT RENT	PATIENT DAYS	565,586	13	77,344	26,943	3,684	21
22									22
23									23
24									24
25	TOTALS					\$ 3,788,533	\$ 2,074,665	\$ 179,189	25

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 2003 report.	\$	25,200	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.)	\$	24,566	2
3. Under or (over) accrual (line 2 minus line 1).	\$	(634)	3
4. Real Estate Tax accrual used for 2004 report. (Detail and explain your calculation of this accrual on the lines below.)	\$	25,000	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.	\$	24,366	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	1999		8
	2000		9
	2001	23,526	10
	2002	24,029	11
	2003	24,566	12

FOR OHF USE ONLY			
13	FROM R. E. TAX STATEMENT FOR 2003	\$	13
14	PLUS APPEAL COST FROM LINE 5	\$	14
15	LESS REFUND FROM LINE 6	\$	15
16	AMOUNT TO USE FOR RATE CALCULATION	\$	16

THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED ON ~ 101% OF THE PRIOR YEAR REAL ESTATE TAX BILL

THE PAYMENT ON LINE 2 APPLIES TO THE 2003 TAX BILL.

NOTES:

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

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2003 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 2003 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2003.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2003 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 2004 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.

2003 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME EAST PEORIA GARDENS HEALTHCARE CENTER COUNTY TAZEWELL

FACILITY IDPH LICENSE NUMBER 0045492

CONTACT PERSON REGARDING THIS REPORT BOB KAGDA

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

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2003 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 2003.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>05-05-09-102-018</u>	<u>NURSING HOME</u>	\$ <u>255.70</u>	\$ <u>255.70</u>
2. <u>05-05-04-301-038</u>	<u>NURSING HOME</u>	\$ <u>24,252.10</u>	\$ <u>24,252.10</u>
3. <u>05-05-04-301-036</u>	<u>NURSING HOME</u>	\$ <u>57.82</u>	\$ <u>57.82</u>
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
	TOTALS	\$ <u>24,565.62</u>	\$ <u>24,565.62</u>

B. Real Estate Tax Cost Allocations

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

If YES, attach an explanation & 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 2003 tax bills which were listed in Section A to this statement. Be sure to use the 2003 tax bill which is normally paid during 2004.

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: _____ B. General Construction Type: Exterior _____ Frame _____ Number of Stories _____

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, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

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

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

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

XI. OWNERSHIP COSTS:

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1	NURSING HOME		2001	\$ 18,625	1
2					2
3	TOTALS			\$ 18,625	3

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9		
Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4		2001		\$ 293,875	\$ 10,686	27.5	\$ 10,686	\$	\$ 34,286	4
5				67,500	2,455	27.5	2,455		6,035	5
6										6
7										7
8	RELATED PARTY				56		56			8
	Improvement Type**									
9	SPRINKLER REPAIR/ALARM PANEL	2001		33,563	1,221	27.5	1,221		3,663	9
10	FENCE	2001		6,500	236	27.5	236		708	10
11	SPRINKLE REPAIR/SMOKE DETECTORS	2002		61,025	2,219	27.5	2,219		5,640	11
12	BASEBOARD HEATING/MIXING VALVE	2002		7,621	277	27.5	277		704	12
13	CONSTRUCTION 2 OFFICES	2003		7,880	286	27.5	286		417	13
14	ARCHITECTURAL DRAWINGS	2003		8,224	299	27.5	299		436	14
15	ELECTRICAL & PLUMBING ENGINEER	2003		6,081	221	27.5	221		322	15
16	RENOVATION 200 WING	2003		111,511	4,055	27.5	4,055		5,914	16
17	FRONT REHABILITATION ROOM	2003		4,975	181	27.5	181		264	17
18	HEATING & A/C REPAIRS	2003		1,125	41	27.5	41		60	18
19	STROBE & SMOKE DETECTION SYSTEM	2003		2,693	98	27.5	98		143	19
20	ASBESTOS CONSULTING & REMOVAL	2004		7,866	131	27.5	131		131	20
21	INTERMEDIATE 200 WING	2004		7,195	120	27.5	120		120	21
22	BASEBOARD HEATING	2004		1,730	29	27.5	29		29	22
23	FIRE SYSTEM NEW ADDITION	2004		5,650	94	27.5	94		94	23
24	ATTIC REPAIRS	2004		5,713	95	27.5	95		95	24
25	PAINTING INTERIOR	2004		29,700	5,940	5	5,940		2,970	25
26	BUMPER, HANDRAILS, CUBICLE TRACKS	2004		18,376	3,675	5	3,675		1,838	26
27										27
28										28
29										29
30										30
31										31
32										32
33										33
34										34
35										35
36										36

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

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

See Page 12A, Line 70 for total

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67								67
68								68
69								69
70	TOTAL (lines 4 thru 69)	\$ 688,803	\$ 32,415		\$ 32,415	\$	\$ 63,869	70

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

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-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	\$ 23,865	\$ 1,210	\$ 2,387	\$ 1,177	10	\$ 7,414	71
72	Current Year Purchases	26,046	15,629	1,302	(14,327)	10	1,302	72
73	Fully Depreciated Assets							73
74	RELATED PARTY	60,000	13,903	11,479	(2,424)	10		74
75	TOTALS	\$ 109,911	\$ 30,742	\$ 15,168	\$ (15,574)		\$ 8,716	75

D. Vehicle Depreciation (See instructions.)*

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

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 817,339	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 63,157	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 47,583	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (15,574)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 72,585	85

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

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

G. Construction-in-Progress

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

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

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

If NO, see instructions. YES NO

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

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

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

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

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

15. Is Movable equipment rental included in building rental?

YES NO

16. Rental Amount for movable equipment: \$ 43,495 Description: SEE SCHEDULE ATTACHED

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$ 0	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. _____ /2005 \$ _____

13. _____ /2006 \$ _____

14. _____ /2007 \$ _____

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

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

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF AIDES TRAINED

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

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the aide 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 aides.

- (e) The total amount of Drop-out and Completed Costs for your own aides 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 aides.

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39-3	hrs	\$		\$ 1,661	\$		\$ 1,661	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			284			284	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			1,607			1,607	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescripts				427		427	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): MEDICAL SUPPLIES	39-2					85		85	13
14	TOTAL			\$		\$ 3,552	\$ 512		\$ 4,064	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 nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number EAST PEORIA GARDENS HEALTHCARE CENTER # 0045492 Report Period Beginning: 01/01/2004 Ending: 12/31/2004
 XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2004 (last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	502,226		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	43,293		6
7	Other Prepaid Expenses	10,608		7
8	Accounts Receivable (owners or related parties)	475,880		8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,032,007	\$	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	327,428		15
16	Equipment, at Historical Cost	49,912		16
17	Accumulated Depreciation (book methods)	(66,081)		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):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 311,259	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,343,266	\$	25

		1	2	
		Operating	After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 317,082	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	1,019,989		29
30	Accrued Salaries Payable	42,499		30
31	Accrued Taxes Payable (excluding real estate taxes)	11,202		31
32	Accrued Real Estate Taxes(Sch.IX-B)	25,000		32
33	Accrued Interest Payable	3,717		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,419,489	\$	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				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,419,489	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ (76,223)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,343,266	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 68,255	1
2	Restatements (describe):		2
3	POST CLOSING ADJUSTMENT	(40,690)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 27,565	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(103,788)	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)	\$ (103,788)	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)	\$ (76,223)	24 *

* This must agree with page 17, line 47.

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

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

1

Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 2,076,055	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,076,055	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 2,076,055	30

2

Expenses		Amount	
A. Operating Expenses			
31	General Services	\$ 534,086	31
32	Health Care	\$ 833,552	32
33	General Administration	\$ 591,188	33
B. Capital Expense			
34	Ownership	\$ 156,300	34
C. Ancillary Expense			
35	Special Cost Centers	\$ 4,064	35
36	Provider Participation Fee	\$ 60,653	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 2,179,843	40
41	Income before Income Taxes (line 30 minus line 40)**	(103,788)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (103,788)	43

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

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

TAX RETURN PREPARED ON CASH BASIS

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

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

Facility Name & ID Number **EAST PEORIA GARDENS HEALTHCARE CENTER**

0045492

Report Period Beginning: **01/01/2004**

Ending:

12/31/2004

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	1,680	1,934	\$ 49,614	\$ 25.65	1
2	Assistant Director of Nursing					2
3	Registered Nurses	4,476	4,639	104,861	22.60	3
4	Licensed Practical Nurses	9,922	10,324	191,968	18.59	4
5	Nurse Aides & Orderlies	31,170	31,782	309,565	9.74	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	2,285	2,355	21,276	9.03	8
9	Activity Director	2,016	2,121	21,712	10.24	9
10	Activity Assistants	1,927	2,008	14,966	7.45	10
11	Social Service Workers	3,451	3,678	46,830	12.73	11
12	Dietician					12
13	Food Service Supervisor	1,952	2,161	28,425	13.15	13
14	Head Cook	5,751	6,004	48,353	8.05	14
15	Cook Helpers/Assistants	7,303	7,546	39,824	5.28	15
16	Dishwashers					16
17	Maintenance Workers	3,344	3,575	31,558	8.83	17
18	Housekeepers	8,105	8,566	72,718	8.49	18
19	Laundry	5,612	5,842	37,323	6.39	19
20	Administrator	1,809	2,041	45,631	22.36	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	1,004	1,081	18,600	17.21	23
24	Clerical	3,926	4,240	61,101	14.41	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	2,021	2,122	18,702	8.81	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	97,754	102,019	\$ 1,163,027 *	\$ 11.40	34

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

** See instructions.

B. CONSULTANT SERVICES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference		
35	Dietary Consultant	M	\$ 5,222	1-3	35
36	Medical Director	O	10,500	9-3	36
37	Medical Records Consultant	N	0	10-3	37
38	Nurse Consultant	T	0	10-3	38
39	Pharmacist Consultant	H	630	10-3	39
40	Physical Therapy Consultant	L	5,400	10a-3	40
41	Occupational Therapy Consultant	Y	5,400	10a-3	41
42	Respiratory Therapy Consultant		0	10a-3	42
43	Speech Therapy Consultant	F	0	10a-3	43
44	Activity Consultant	E	0	11-3	44
45	Social Service Consultant	E	2,049	12-3	45
46	Other(specify)	S			46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 29,201		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses		\$ 0	10-3	50
51	Licensed Practical Nurses		0	10-3	51
52	Nurse Aides		0	10-3	52
53	TOTAL (lines 50 - 52)		\$		53

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions		
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount		
GERALD BOCK	ADMIN	0	\$ 45,631	Workers' Compensation Insurance	\$ 31,543	IDPH License Fee	\$		
				Unemployment Compensation Insurance	43,943	Advertising: Employee Recruitment	4,187		
				FICA Taxes	87,740	Health Care Worker Background Check	35		
				Employee Health Insurance	14,518	(Indicate # of checks performed <u>3</u>)			
				Employee Meals	12,407	MARKETING/ADV/PROMO	8,789		
				Illinois Municipal Retirement Fund (IMRF)*		TRUST/FRANCHISE/CONTRIB/ETC	50		
				EMPLOYEE BENEFITS - OTHER	1,500	LICENSES & PERMITS	1,673		
				EMPLOYEE PHYSICAL EXAMS	0	DUES & SUBSCRIPTIONS	0		
				PENSION/PROFIT SHARING PLANS	0	MGMT CO ALLOCATION	1,685		
				CHICAGO HEAD TAX	0	TRUST/FRANCHISE/CONTRIB/ETC	(50)		
				INSURANCE - EXECUTIVE LIFE	0	Less: Public Relations Expense	(0)		
				INSURANCE - EXECUTIVE LIFE VI 21	0	Non-allowable advertising	(2,613)		
						Yellow page advertising	(6,176)		
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)				TOTAL (agree to Schedule V, line 22, col.8)			TOTAL (agree to Sch. V, line 20, col. 8)		
\$ 45,631				\$ 191,651			\$ 7,580		
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**		
Description			Amount	Description	Line #	Amount	Description	Amount	
CAREPLUS MANAGEMENT			\$ 50,000			\$	Out-of-State Travel	\$	
							In-State Travel	502	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)				TOTAL			Seminar Expense		0
\$ 50,000				\$			MGMT CO ALLOCATION		227
C. Professional Services							Entertainment Expense		
Vendor/Payee	Type		Amount				(agree to Sch. V, line 24, col. 8)		
NATIONAL DATACARE	DATA PROCESSING		\$ 2,290				TOTAL		\$ 729
AMERICAN DATA	DATA PROCESSING		2,065						
ACHIEVE HEALTHCARE	DATA PROCESSING		4,784						
e-HEALTH DATA SOLUTIONS	DATA PROCESSING		825						
KRUPNICK BOKOR	ACCOUNTING		31,100						
MEYER MAGENCE	LEGAL		2,318						
SACHNOFF & WEAVER	LEGAL		10,171						
PERSONNEL PLANNERS	U C CONSULTANT		1,683						
P K BHOSOLE	ARCHITECT		320						
CIB BANK	APPRAISAL		3,200						
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$2500 attach copy of invoices.)				TOTAL					
\$ 58,756				\$					

* Attach copy of IMRF notifications

**See instructions.

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

(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009
1			\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$ 0	\$	\$	\$	\$	\$

Facility Name & ID Number EAST PEORIA GARDENS HEALTHCARE CENTER

0045492

Report Period Beginning: 01/01/2004

Ending: 12/31/2004

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? NO
If YES, give association name and amount. _____
- (3) Did the nursing home make political contributions or payments to a political 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 YR
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ _____ Line 10-2
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? NO
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? _____ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 60,653
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? NO If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, 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. \$ 12,407 Has any meal income been offset against related costs? _____ Indicate the amount. \$ _____
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? NO
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? 5%
d. Have vehicle usage logs been maintained? NO
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? NO
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? YES
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? NO
Firm Name: _____ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? _____ If no, please explain. _____
- (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 \$2500, 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