

Facility Name & ID Number PARK HOUSE

0034991 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 _____

	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	14	Skilled (SNF)	14	5,124	1
2		Skilled Pediatric (SNF/PED)			2
3	92	Intermediate (ICF)	92	33,672	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	106	TOTALS	106	38,796	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			3,430	3,430	8
9	SNF/PED					9
10	ICF	31,166	2		31,168	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	31,166	2	3,430	34,598	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 89.18%

D. How many bed-hold days during this year were paid by Public Aid? 142 (Do not include bed-hold days in Section B.)

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

NONE

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

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

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

I. On what date did you start providing long term care at this location?
Date started 01/01/89

J. Was the facility purchased or leased after January 1, 1978?
YES Date 01/01/89 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 3,430

Medicare Intermediary ADMINISTAR

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 **PARK HOUSE** # **0034991** 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	157,696	15,467	9,970	183,133		183,133	(1,430)	181,703		1
2	Food Purchase		140,434		140,434	(13,396)	127,038	(234)	126,804		2
3	Housekeeping	97,353	23,675		121,028		121,028		121,028		3
4	Laundry	31,537	6,266		37,803		37,803		37,803		4
5	Heat and Other Utilities			82,672	82,672		82,672	479	83,151		5
6	Maintenance	18,738	38,440	29,491	86,669		86,669	4,883	91,552		6
7	Other (specify):*			10,328	10,328		10,328	252	10,580		7
8	TOTAL General Services	305,324	224,282	132,461	662,067	(13,396)	648,671	3,950	652,621		8
	B. Health Care and Programs										
9	Medical Director			8,400	8,400		8,400		8,400		9
10	Nursing and Medical Records	823,444	28,583	252,060	1,104,087		1,104,087	(231,569)	872,518		10
10a	Therapy	26,698	1,407	42,570	70,675		70,675	(180,015)	(109,340)		10a
11	Activities	58,818	8,969	2,049	69,836		69,836		69,836		11
12	Social Services	152,777		1,546	154,323		154,323		154,323		12
13	Nurse Aide Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,061,737	38,959	306,625	1,407,321		1,407,321	(411,584)	995,737		16
	C. General Administration										
17	Administrative	65,517		275,600	341,117		341,117	(170,189)	170,928		17
18	Directors Fees										18
19	Professional Services			284,683	284,683		284,683	(217,406)	67,277		19
20	Dues, Fees, Subscriptions & Promotions			17,372	17,372		17,372	(1,796)	15,576		20
21	Clerical & General Office Expenses	115,985	8,263	88,871	213,119		213,119	10,188	223,307		21
22	Employee Benefits & Payroll Taxes			272,945	272,945	13,396	286,341		286,341		22
23	Inservice Training & Education			1,400	1,400		1,400	886	2,286		23
24	Travel and Seminar							292	292		24
25	Other Admin. Staff Transportation			369	369		369	2,945	3,314		25
26	Insurance-Prop.Liab.Malpractice			46,437	46,437		46,437	1,853	48,290		26
27	Other (specify):*							32,664	32,664		27
28	TOTAL General Administration	181,502	8,263	987,677	1,177,442	13,396	1,190,838	(340,563)	850,275		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,548,563	271,504	1,426,763	3,246,830		3,246,830	(748,197)	2,498,633		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	7,934
	REPAIRS & MAINTENANCE		2,036
			0
			9,970
3	HOUSEKEEPING		
			0
			0
			0
4	LAUNDRY		
	EQUIPMENT REPAIRS & MAINTENANCE		0
			0
			0
5	HEAT & OTHER UTILITIES		
	GAS HEAT		39,986
	ELECTRICITY		27,318
	WATER		14,397
	CABLE TV - LOBBY		971
			0
			82,672
6	MAINTENANCE		
	GROUNDS MAINTENANCE		5,774
	PAINTING & DECORATING		0
	BUILDING REPAIRS		0
	MAINTENANCE TRAVEL		0
	EQUIPMENT MAINTENANCE & REPAIR		11,865
	ELEVATOR MAINTENANCE & REPAIR		4,374
	OUTSIDE LABOR		0
	EXTERMINATING SERVICE		3,685
	FIRE SERVICE		3,793
			0
			0
			0
			29,491
7	OTHER		
	SCAVENGER		10,328
	SECURITY SERVICE		0
			10,328
9	MEDICAL DIRECTOR		
	MEDICAL DIRECTOR FEES	XVIII B 36-2	8,400
			8,400

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	1,760
	PHARMACY CONSULTANT	XVIII B 39-2	300
	UTILIZATION REVIEW FEES	XVIII B ___-2	0
	PHYSICIANS	XVIII B ___-2	0
	PSYCHIATRIC	XVIII B 46-2	100,000
	RN CONSULTANT	XVIII B 38-2	0
	MEDICARE/PUBLIC AID	XVIII B 47-2	150,000
			0
			252,060
10a	THERAPY		
	PHYSICAL THERAPY SERVICES		2,052
	THERAPY CONTRACT SERVICES		29,664
	OCCUPATIONAL THERAPY SERVICES		54
	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
			42,570
11	ACTIVITIES		
	CABLE TV - PATIENT ROOMS		0
	ACTIVITY REHAB CONSULTANT	XVIII B 44-2	2,049
			0
			2,049
12	SOCIAL SERVICES		
	SOCIAL REHABILITATION SERVICES		0
	SOCIAL REHABILITATION CONSULTAN	XVIII B 45-2	0
	SOCIAL WORKER	XVIII B 45-2	1,546
			0
			1,546
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	275,600
18	DIRECTORS FEES	0
19	PROFESSIONAL SERVICES	
	DATA PROCESSING XIX C	22,352
	ADMINISTRATIVE CONSULTANTS XIX C	206,000
	PROFESSIONAL FEES XIX C	56,331
		0
		284,683
20	FEES,SUBSCRIPTIONS,PROMOTIONS	
	ENTERTAINMENT & MARKETING VI 19 XIX F	0
	ADV & PROMO-NON PATIENT RELATED VI 25 XIX F	3,699
	EMPLOYEE WANT ADS XIX F	11,117
	CONTRIBUTIONS VI 20 XIX F	50
	DUES & SUBSCRIPTIONS XIX F	600
	LICENSES & PERMITS XIX F	1,696
	PUBLIC RELATIONS-PATIENT RELATED XIX F	0
	ADVERTISING-YELLOW PAGES VI 28 XIX F	56
	TRUST FEES / FRANCHISE TAX / ETC VI 17 XIX F	154
	CONTRIBUTIONS - POLITICAL VI 20 XIX F	0
	HEALTH CARE WORKER BACKGROUND CHEC XIX F	0
		17,372
21	CLERICAL & GENERAL OFFICE EXPENSES	
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)	8,036
	EQUIPMENT REPAIR & MAINTENANCE	5,224
	OUTSIDE CLERICAL SERVICES	63,600
	PENALTIES / OVERDRAFT CHARGES VI 18	293
	HOME OFFICE EXPENSE	0
	THEFT & DAMAGE LOSS	0
	TELEPHONE	11,334
	MESSENGER SERVICE	384
		0
		88,871

LINE	SCHED REF	TOTAL
22	EMPLOYEE BENEFITS & PAYROLL TAXES	
	FICA TAXES XIX D	117,624
	UNEMPLOYMENT COMPENSATION XIX D	30,983
	WORKERS COMPENSATION INSURANCE XIX D	39,499
	HOSPITALIZATION INSURANCE XIX D	63,791
	EMPLOYEE BENEFITS - OTHER XIX D	553
	EMPLOYEE PHYSICAL EXAMS XIX D	0
	INSURANCE - EXECUTIVE LIFE VI 21/XIX D	0
	PENSION/PROFIT SHARING PLANS XIX D	16,587
	CHICAGO HEAD TAX XIX D	3,908
		272,945
23	INSERVICE TRAINING & EDUCATION	
	EDUCATION & SEMINARS	1,400
		1,400
24	TRAVEL & SEMINARS	
	EDUCATION & SEMINARS XIX G	0
	TRAVEL XIX G	0
		0
		0
		0
25	ADMIN. STAFF TRANSPORTATION	
	TRANSPORTATION - STAFF	369
		369
26	INSURANCE - PROP. LIAB & MALPRACTICE	
	GENERAL INSURANCE	46,437
		46,437
27	OTHER	
	BAD DEBTS VI 24	0
		0

GRAND TOTAL COLUMN 3 OTHER

1,426,763

PARK HOUSE
 EMPLOYEE MEAL RECLASSIFICATION (PAGE 3 SCHEDULE V COLUMN 5 LINES 2 AND 22)
 12/31/2004

TOTAL FOOD PURCHASE	140,434	PATIENT MEALS	103794
LESS SALES TAX	(234)	ADD EMPLOYEE MEALS	10980
	-----		-----
NET FOOD	140,200	TOTAL MEALS/YEAR	114774
TOTAL PATIENT CENSUS	34,598	NET FOOD	140200
TIME 3 MEALS PER DAY	3	DIVIDE TOTAL MEALS/YEAR	114774

TOTAL PATIENT MEALS	103794	COST PER MEAL	1.22
		TIME EMPLOYEE MEALS	10980
ADD # EMPLOYEE MEALS/DAY	30		-----
TIME # DAYS	366	EMPLOYEE MEAL RECLASSIFICATION	13396
	-----		=====
TOTAL EMPLOYEE MEALS	10980		

Facility Name & ID Number **PARK HOUSE**

#0034991

Report Period Beginning:

01/01/2004

Ending:

12/31/2004

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			27,510	27,510		27,510	51,545	79,055			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							278,916	278,916			32
33	Real Estate Taxes			82,046	82,046		82,046		82,046			33
34	Rent-Facility & Grounds			344,254	344,254		344,254	(339,893)	4,361			34
35	Rent-Equipment & Vehicles			29,295	29,295		29,295	(10,260)	19,035			35
36	Other (specify):*											36
37	TOTAL Ownership			483,105	483,105		483,105	(19,692)	463,413			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		73,542	221,010	294,552		294,552	(37,676)	256,876			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			58,194	58,194		58,194		58,194			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		73,542	279,204	352,746		352,746	(37,676)	315,070			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,548,563	345,046	2,189,072	4,082,681		4,082,681	(805,565)	3,277,116			45

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

Facility Name & ID Number **PARK HOUSE**

0034991

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

Ending: **12/31/2004**

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	1,107	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	(234)	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	(154)	20		17
18	Fines and Penalties	(293)	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	(2,137)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt		27		24
25	Fund Raising, Advertising and Promotional	(3,699)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(56)	20		28
29	Other-Attach Schedule				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (5,516)		\$	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)	(800,049)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (800,049)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (805,565)		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

PARK HOUSE

ID# 0034991

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			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			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	0	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number PARK HOUSE# 0034991

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 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
1	A. General Services													
1	Dietary	0	0	(3,500)	2,070	0	0	0	0	0	0	0	(1,430)	1
2	Food Purchase	(234)	0	0	0	0	0	0	0	0	0	0	(234)	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	0	479	0	0	0	0	0	0	0	479	5
6	Maintenance	0	0	0	4,883	0	0	0	0	0	0	0	4,883	6
7	Other (specify):*	0	0	0	252	0	0	0	0	0	0	0	252	7
8	TOTAL General Services	(234)	0	(3,500)	7,684	0	3,950	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	(250,000)	18,431	0	0	0	0	0	0	0	(231,569)	10
10a	Therapy	0	(182,450)	0	2,435	0	0	0	0	0	0	0	(180,015)	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	(182,450)	(250,000)	20,866	0	(411,584)	16						
	C. General Administration													
17	Administrative	0	0	(219,600)	49,411	0	0	0	0	0	0	0	(170,189)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(2,137)	0	(218,000)	2,731	0	0	0	0	0	0	0	(217,406)	19
20	Fees, Subscriptions & Promotions	(3,959)	0	0	2,163	0	0	0	0	0	0	0	(1,796)	20
21	Clerical & General Office Expenses	(293)	0	(63,600)	74,081	0	0	0	0	0	0	0	10,188	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	0	886	0	0	0	0	0	0	0	886	23
24	Travel and Seminar	0	0	0	292	0	0	0	0	0	0	0	292	24
25	Other Admin. Staff Transportation	0	0	0	2,945	0	0	0	0	0	0	0	2,945	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	1,853	0	0	0	0	0	0	0	1,853	26
27	Other (specify):*	0	0	0	32,664	0	0	0	0	0	0	0	32,664	27
28	TOTAL General Administration	(6,389)	0	(501,200)	167,026	0	(340,563)	28						
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(6,623)	(182,450)	(754,700)	195,576	0	(748,197)	29						

STATE OF ILLINOIS

Summary B

Facility Name & ID Number PARK HOUSE# 0034991

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 TOTALS (to Sch V, col.7)	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I		
30	Depreciation	1,107	43,329	0	7,109	0	0	0	0	0	0	0	51,545	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	258,520	0	20,396	0	0	0	0	0	0	0	278,916	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	(344,254)	0	4,361	0	0	0	0	0	0	0	(339,893)	34
35	Rent-Equipment & Vehicles	0	(14,991)	0	4,731	0	0	0	0	0	0	0	(10,260)	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	1,107	(57,396)	0	36,597	0	(19,692)	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	(37,676)	0	0	0	0	0	0	0	0	0	(37,676)	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	(37,676)	0	0	0	0	0	0	0	0	0	(37,676)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(5,516)	(277,522)	(754,700)	232,173	0	(805,565)	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	MGMT/CLERICAL
				CAREPLUS REHABILITATIVE SERVICES		
					NILES	THERAPY
				2320 S LAWNSDALE	NILES	REAL ESTATE

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V	34 RENT	\$ 344,254	2320 S LAWNSDALE LLC	100.00%	\$	\$ (344,254)	1
2	V	30 SL DEPRECIATION		" "		43,329	43,329	2
3	V	32 INTEREST		" "		258,520	258,520	3
4	V							4
5	V							5
6	V	10a THERAPY SERVICES	218,138	CAREPLUS REHABILITATIVE SERVICES		35,688	(182,450)	6
7	V	39 ANCILLARY SERVICES	42,570	" "		4,894	(37,676)	7
8	V	35 EQUIPMENT RENT	14,991				(14,991)	8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 619,953			\$ 342,431	\$ * (277,522)	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 CONSULTANT	\$ 3,500	CAREPLUS MGMT INC	100.00%	\$	\$ (3,500) 15
16	V	10 MEDICARE CONSULTANT	50,000	" "			(50,000) 16
17	V	10 PUBLIC AID CONSULTANT	100,000	" "			(100,000) 17
18	V	10 PSYCHIATRIC CONSULTANT	100,000	" "			(100,000) 18
19	V	17 MANAGEMENT FEE	219,600	" "			(219,600) 19
20	V	19 ADMIN CONSULTANT	206,000	" "			(206,000) 20
21	V	19 DATA PROCESSING	12,000	" "			(12,000) 21
22	V	21 CLERICAL FEES	63,600	" "			(63,600) 22
23	V						
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 754,700			\$ 0	\$ * (754,700) 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	1	DIETARY SALARIES	\$	CAREPLUS MGMT INC	100.00%	\$ 2,070	\$ 2,070	15
16	V	5	UTILITIES		" " "		479	479	16
17	V	6	MAINT & REPAIRS		" " "		17	17	17
18	V	6	MAINTENANCE SALARIES		" " "		4,866	4,866	18
19	V	7	SECURITY		" " "		252	252	19
20	V	10	NURSING SALARIES		" " "		18,431	18,431	20
21	V	10a	THERAPY SALARIES		" " "		2,435	2,435	21
22	V	17	ADMIN SALARIES		" " "		49,411	49,411	22
23	V	19	PROFESSIONAL FEES		" " "		2,731	2,731	23
24	V	20	ADVERTISING		" " "		2,163	2,163	24
25	V	21	OFFICE EXPENSE		" " "		23,963	23,963	25
26	V	21	OFFICE SALARIES		" " "		50,118	50,118	26
27	V	23	SEMINARS		" " "		886	886	27
28	V	24	TRAVEL		" " "		292	292	28
29	V	25	TRANSPORTATION		" " "		2,945	2,945	29
30	V	26	INSURANCE		" " "		1,853	1,853	30
31	V	27	EMPLOYEE BENEFITS		" " "		32,664	32,664	31
32	V	30	DEPRECIATION		" " "		7,109	7,109	32
33	V	32	INTEREST		" " "		20,396	20,396	33
34	V	34	OFFICE RENT		" " "		4,361	4,361	34
35	V	35	EQUIPMENT RENT		" " "		4,731	4,731	35
36	V								36
37	V								37
38	V								38
39	Total		\$				\$ 232,173	\$ * 232,173	39

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

Facility Name & ID Number

PARK HOUSE

0034991

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	CAREPLUS MGMT ALLOCATIONS:								\$		1	
2	JAKOB BAKST	DIR OPERATIONS	ADMIN, CONSULT		SEE ATTACHED			SALARY	11,360		17-7	2
3	SHERWIN I RAY	PRESIDENT	ADMIN, FINANCE		SCHEDULE			SALARY	11,360		17-7	3
4	ERIC ROTHNER							MGMT FEE	56,000		17-3	4
5												5
6												6
7												7
8												8
9												9
10												10
11												11
12												12
13								TOTAL	\$ 78,720			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 **PARK HOUSE**

0034991 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

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

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

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	451,049	9	\$ 26,990	\$ 26,990	34,598	\$ 2,070	1
2	5	UTILITIES	PATIENT DAYS	565,586	13	7,834		34,598	479	2
3	6	MAINT & REPAIRS	PATIENT DAYS	565,586	13	275		34,598	17	3
4	6	MAINTENANCE SALARIES	PATIENT DAYS	565,586	13	79,548	79,548	34,598	4,866	4
5	7	SECURITY	PATIENT DAYS	565,586	13	4,112		34,598	252	5
6	10	NURSING SALARIES	PATIENT DAYS	565,586	13	301,295	301,295	34,598	18,431	6
7	10a	THERAPY SALARIES	PATIENT DAYS	565,586	13	39,798	39,798	34,598	2,435	7
8	17	ADMIN SALARIES	PATIENT DAYS	565,586	13	807,745	807,745	34,598	49,411	8
9	19	PROFESSIONAL FEES	PATIENT DAYS	565,586	13	44,637		34,598	2,731	9
10	20	ADVERTISING	PATIENT DAYS	565,586	13	35,362		34,598	2,163	10
11	21	OFFICE EXPENSE	PATIENT DAYS	565,586	13	391,736		34,598	23,963	11
12	21	OFFICE SALARIES	PATIENT DAYS	565,586	13	819,289	819,289	34,598	50,118	12
13	23	SEMINARS	PATIENT DAYS	565,586	13	14,490		34,598	886	13
14	24	TRAVEL	PATIENT DAYS	565,586	13	4,769		34,598	292	14
15	25	TRANSPORTATION	PATIENT DAYS	565,586	13	48,136		34,598	2,945	15
16	26	INSURANCE	PATIENT DAYS	565,586	13	30,286		34,598	1,853	16
17	27	EMPLOYEE BENEFITS	PATIENT DAYS	565,586	13	533,964		34,598	32,664	17
18	30	DEPRECIATION	PATIENT DAYS	565,586	13	116,219		34,598	7,109	18
19	32	INTEREST	PATIENT DAYS	565,586	13	333,416		34,598	20,396	19
20	34	OFFICE RENT	PATIENT DAYS	565,586	13	71,288		34,598	4,361	20
21	35	EQUIPMENT RENT	PATIENT DAYS	565,586	13	77,344		34,598	4,731	21
22										22
23										23
24										24
25	TOTALS					\$ 3,788,533	\$ 2,074,665		\$ 232,173	25

Facility Name & ID Number

PARK HOUSE

0034991

Report Period Beginning:

01/01/2004

Ending:

12/31/2004

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	Name of Lender	2		3	4	5	6		7	8	9	10						
		Related**					Purpose of Loan	Monthly Payment Required					Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO											Original	Balance			
A. Directly Facility Related																		
Long-Term																		
1	RELATED PARTY: 2320 S.LAWNDALE LLC						\$	\$			\$	1						
2	NOMURA		X	MORTGAGE	\$26,467.97	12/95	3,185,096	2,763,007	11/10/07	9.2500	252,665	2						
3												3						
4	CAREPLUS MANAGEMENT	X		CAPITAL IMPR LOAN				84,607			5,855	4						
5												5						
Working Capital																		
6												6						
7												7						
8												8						
9	TOTAL Facility Related				\$26,467.97		\$ 3,185,096	\$ 2,847,614			\$ 258,520	9						
B. Non-Facility Related*																		
10												10						
11												11						
12												12						
13												13						
14	TOTAL Non-Facility Related						\$	\$			\$	14						
15	TOTALS (line 9+line14)						\$ 3,185,096	\$ 2,847,614			\$ 258,520	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.)

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.	\$	75,600	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.)	\$	78,046	2
3. Under or (over) accrual (line 2 minus line 1).	\$	2,446	3
4. Real Estate Tax accrual used for 2004 report. (Detail and explain your calculation of this accrual on the lines below.)	\$	79,600	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.	\$	82,046	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	1999	63,156	8
	2000	71,075	9
	2001	72,924	10
	2002	73,742	11
	2003	78,046	12

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

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

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

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 PARK HOUSE COUNTY COOK

FACILITY IDPH LICENSE NUMBER 0034991

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>16-26-105-075-0000</u>	<u>NURSING HOME</u>	\$ <u>34,450.97</u>	\$ <u>34,450.97</u>
2. <u>16-26-105-080-0000</u>	<u>NURSING HOME</u>	\$ <u>21,831.93</u>	\$ <u>21,831.93</u>
3. <u>16-26-105-079-0000</u>	<u>NURSING HOME</u>	\$ <u>21,762.77</u>	\$ <u>21,762.77</u>
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>78,045.67</u>	\$ <u>78,045.67</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.

Facility Name & ID Number PARK HOUSE

0034991

Report Period Beginning:

01/01/2004 Ending:

12/31/2004

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 26,849 B. General Construction Type: Exterior BRICK 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	<u>NURSING HOME</u>	<u>51,000</u>	<u>1995</u>	<u>\$ 100,000</u>	<u>1</u>
2					<u>2</u>
3	TOTALS	51,000		\$ 100,000	3

Facility Name & ID Number **PARK HOUSE**# **0034991**

Report Period Beginning:

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

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					\$	\$		\$	\$	\$	4
5	106		1989		1,209,350	38,261	39	38,261		612,607	5
6											6
7											7
8	RELATED PARTY					72		72			8
	Improvement Type**										
9		LEASEHOLD IMPROVEMENTS	1989		17,739	563	20	887	324	13,546	9
10		LEASEHOLD IMPROVEMENTS	1989		4,204	280	15	280		4,410	10
11		LEASEHOLD IMPROVEMENTS	1990		11,700	371	20	585	214	8,379	11
12		LEASEHOLD IMPROVEMENTS	1991		17,413	553	20	871	318	11,758	12
13		LEASEHOLD IMPROVEMENTS	1992		55,138	1,858	31.5	1,750	(108)	22,196	13
14		LEASEHOLD IMPROVEMENTS	1993		26,399	748	31.5	838	90	9,637	14
15		LEASEHOLD IMPROVEMENTS	1994		3,400	87	39	87		939	15
16		ROOF REPAIR	1995		1,500	38	39	38		363	16
17		ROOF-TOP HEAT/A/C	1996		10,000	256	39	256		2,273	17
18		CEILING TILE/DUMBWAITER REPAIR	1996		12,253	314	39	314		2,709	18
19		RE-ROOF	1996		80,861	2,073	39	2,073		17,273	19
20		FIXTURES/WINDOWS	1996		3,850	99	39	99		811	20
21		WINDOWS	1997		18,900	484	39	484		3,554	21
22		ROOF REPAIR & ROOF-TOP HEAT/A/C INSTALLATION	1997		3,228	83	39	83		620	22
23		DOOR & FLOORING	1997		2,922	75	39	75		566	23
24		ELEVATOR REPAIR	1997		3,125	80	39	80		590	24
25		WINDOWS	1998		12,600	323	39	323		2,181	25
26		TILE & FLOORING	1998		23,810	611	39	611		4,108	26
27		ELECTRICAL, PLUMBING AND ELEVATOR REPAIR	1998		31,238	801	39	801		5,315	27
28		NEW NURSE STATION	1998		24,271	622	39	622		4,277	28
29		WINDOW TREATMENTS AND BRAILLE SIGNS	1998		3,478	89	39	89		597	29
30		FIRE SYSTEM UPGRADE AND DAMPERS	1998		8,833	227	39	227		1,435	30
31		REAR PARKING LOT REPAIRS	1998		10,550	703	15	703		4,573	31
32		WINDOWS/CLOSETS/OUTLETS/DUMBWAITS/ROOF	1999		23,174	594	39	594		3,391	32
33		ROOF REPAIR	1999		18,365	471	39	471		2,610	33
34		FRONT RAMP REPAIR	2000		1,200	44	27.5	44		162	34
35		VINYL TILE/KITCHEN	2000		6,213	226	27.5	226		1,008	35
36											36

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

See Page 12A, Line 70 for total

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

Facility Name & ID Number **PARK HOUSE**

0034991

Report Period Beginning:

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

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	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	DUMBWAITER REPAIR	2001	\$ 3,264	\$ 119	27.5	\$ 119	\$	\$ 451	37
38	SIDEWALK/TUCKPOINTING	2001	5,500	367	15	367		1,284	38
39	KEYPAD ENTRY SYSTEM	2001	3,800	138	27.5	138		431	39
40	BOILER	2002	5,229	190	27.5	190		467	40
41	AC UNITS	2002	6,365	231	27.5	231		568	41
42	FLOORING	2002	2,328	85	27.5	85		209	42
43	FIRE PUMP REPAIR	2003	1,750	63	27.5	63		92	43
44	ELECTRICAL TO ROOFTOP UNIT	2003	1,951	71	27.5	71		104	44
45	PAINTING	2003	20,800	757	27.5	757		1,104	45
46	CEILING & DOOR REPAIR	2003	1,180	43	27.5	43		63	46
47	CONCRETE REPAIRS	2003	2,961	108	27.5	108		158	47
48	LIGHT FIXTURE	2004	969	16	27.5	16		16	48
49	REBUILD NEW BATHROOMS	2004	7,478	125	27.5	125		125	49
50	WINDOWS	2004	22,770	380	27.5	380		380	50
51	FLOORING	2004	30,110	502	27.5	502		502	51
52	WATER PUMP	2004	2,547	42	27.5	42		42	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)		\$ 1,764,716	\$ 54,243		\$ 55,081	\$ 838	\$ 747,884	70

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

Facility Name & ID Number **PARK HOUSE**

0034991

Report Period Beginning:

01/01/2004

Ending:

12/31/2004

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	\$ 186,070	\$ 13,550	\$ 16,677	\$ 3,127	10 YRS	\$ 105,840	71
72	Current Year Purchases	5,196	3,118	260	(2,858)	10 YRS	260	72
73	Fully Depreciated Assets	89,112				10 YRS	89,112	73
74	RELATED PARTY		7,037	7,037				74
75	TOTALS	\$ 280,378	\$ 23,705	\$ 23,974	\$ 269		\$ 195,212	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)	\$ 2,145,094	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 77,948	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 79,055	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 1,107	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 943,096	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: \$ 29,295 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	\$		\$ 153,284	\$		\$ 153,284	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			1,026			1,026	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			63,829			63,829	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				73,302		73,302	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	SUPPLIES, LAB, RENT, RADIOLOGY Other (specify):	39-2 & 39-3				2,871	240		3,111	13
14	TOTAL			\$		\$ 221,010	\$ 73,542		\$ 294,552	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 **PARK HOUSE**# **0034991**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 <u>30,535</u>)	1,514,951		3
4	Supply Inventory (priced at _____)			4
5	Short-Term Investments			5
6	Prepaid Insurance	1,178		6
7	Other Prepaid Expenses	19,342		7
8	Accounts Receivable (owners or related parties)	890,393		8
9	Other(specify): <u>RE TAX ESCROW</u>	67,299		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,493,163	\$	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	395,620		15
16	Equipment, at Historical Cost	280,378		16
17	Accumulated Depreciation (book methods)	(315,253)		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): <u>REPLACEMENT RESERVE</u>	82,613		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 443,358	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,936,521	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 524,619	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	90,158		30
31	Accrued Taxes Payable (excluding real estate taxes)	12,081		31
32	Accrued Real Estate Taxes(Sch.IX-B)	79,600		32
33	Accrued Interest Payable			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)	\$ 706,458	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	55,947		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)	\$ 55,947	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 762,405	\$	46
47	TOTAL EQUITY (page 18, line 24)	\$ 2,174,116	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,936,521	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 2,551,058	1
2	Restatements (describe):		2
3	POST CLOSING ADJUSTMENT	(647,868)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,903,190	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	270,926	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)	\$ 270,926	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 2,174,116	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	\$ 4,288,522	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,288,522	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***	65,085	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 65,085	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)	\$ 4,353,607	30

2

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	662,067	31
32	Health Care	1,407,321	32
33	General Administration	1,177,442	33
	B. Capital Expense		
34	Ownership	483,105	34
	C. Ancillary Expense		
35	Special Cost Centers	294,552	35
36	Provider Participation Fee	58,194	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 4,082,681	40
41	Income before Income Taxes (line 30 minus line 40)**	270,926	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 270,926	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 PARK HOUSE

0034991

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	2,109	2,306	\$ 60,407	\$ 26.20	1
2	Assistant Director of Nursing	1,240	1,297	28,325	21.84	2
3	Registered Nurses	759	782	22,457	28.72	3
4	Licensed Practical Nurses	13,431	13,792	276,640	20.06	4
5	Nurse Aides & Orderlies	43,877	47,370	417,032	8.80	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,915	2,158	26,698	12.37	8
9	Activity Director	2,735	2,887	26,777	9.28	9
10	Activity Assistants	3,233	3,357	32,041	9.54	10
11	Social Service Workers	9,425	10,186	152,777	15.00	11
12	Dietician					12
13	Food Service Supervisor	1,936	2,121	31,382	14.80	13
14	Head Cook	5,268	5,837	56,364	9.66	14
15	Cook Helpers/Assistants	8,609	9,331	69,950	7.50	15
16	Dishwashers					16
17	Maintenance Workers	1,764	1,867	18,738	10.04	17
18	Housekeepers	10,546	11,519	97,353	8.45	18
19	Laundry	4,300	4,429	31,537	7.12	19
20	Administrator	1,937	2,146	51,299	23.90	20
21	Assistant Administrator	1,016	1,098	14,218	12.95	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	7,079	7,723	115,985	15.02	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,034	2,123	18,583	8.75	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	123,213	132,329	\$ 1,548,563 *	\$ 11.70	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	\$ 7,934	1-3	35
36	Medical Director	O	8,400	9-3	36
37	Medical Records Consultant	N	1,760	10-3	37
38	Nurse Consultant	T	0	10-3	38
39	Pharmacist Consultant	H	300	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	2,049	11-3	44
45	Social Service Consultant	E	1,546	12-3	45
46	Other(specify) <u>PSYCHIATRIC</u>	S	100,000	10-3	46
47	<u>MEDICARE/PUBLIC AID</u>		150,000	10-3	47
48					48
49	TOTAL (lines 35 - 48)		\$ 282,789		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	
CALLIE GRAHAM	ADMIN		\$ 51,299	Workers' Compensation Insurance	\$ 39,499	IDPH License Fee	\$ 0	
PATRICIA WILLIAMS-SMITH	ASST ADMIN		14,218	Unemployment Compensation Insurance	30,983	Advertising: Employee Recruitment	11,117	
				FICA Taxes	117,624	Health Care Worker Background Check	0	
				Employee Health Insurance	63,791	(Indicate # of checks performed _____)		
				Employee Meals	13,396	MARKETING/ADV/PROMO	3,755	
				Illinois Municipal Retirement Fund (IMRF)*		TRUST/FRANCHISE/CONTRIB/ETC	204	
				EMPLOYEE BENEFITS - OTHER	553	LICENSES & PERMITS	1,696	
				EMPLOYEE PHYSICAL EXAMS	0	DUES & SUBSCRIPTIONS	600	
				PENSION/PROFIT SHARING PLANS	16,587	MGMT CO ALLOCATION	2,163	
				CHICAGO HEAD TAX	3,908	TRUST/FRANCHISE/CONTRIB/ETC	(204)	
				INSURANCE - EXECUTIVE LIFE	0	Less: Public Relations Expense	(0)	
				INSURANCE - EXECUTIVE LIFE VI 21	0	Non-allowable advertising	(3,699)	
						Yellow page advertising	(56)	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 65,517	TOTAL (agree to Schedule V, line 22, col.8)	\$ 286,341	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 15,576	
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			\$ 219,600				Out-of-State Travel	\$
HUNTER MANAGEMENT			56,000					
							In-State Travel	0
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 275,600				Seminar Expense	0
							MGMT CO ALLOCATION	292
C. Professional Services							Entertainment Expense	()
Vendor/Payee	Type		Amount				(agree to Sch. V, line 24, col. 8)	
			\$				TOTAL	\$ 292
SEE SCHEDULE ATTACHED			284,683					
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$2500 attach copy of invoices.)			\$ 284,683	TOTAL		\$		

* 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								
													Amount of Expense Amortized Per Year							
													Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	FY2001	FY2002	FY2003	FY2004
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 PARK HOUSE# 0034991Report Period Beginning: 01/01/2004Ending: 12/31/2004**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? YES
- (2) Are there any dues to nursing home associations included on the cost report? NO
If YES, give association name and amount. _____
- (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 YR
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 761 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. \$ 58,194
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. \$ 13,396 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