

		FOR OHF USE					

LL1

**2005**  
**STATE OF ILLINOIS**  
**DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES**  
**FINANCIAL AND STATISTICAL REPORT FOR**  
**LONG-TERM CARE FACILITIES**  
**(FISCAL YEAR 2005)**

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><b>I. IDPH Facility ID Number:</b> <u>0044602</u></p> <p><b>Facility Name:</b> <u>OAK PARK HEALTHCARE CENTER</u></p> <p><b>Address:</b> <u>625 NORTH HARLEM</u> <u>OAK PARK</u> <u>60302</u>          Number City Zip Code</p> <p><b>County:</b> <u>COOK</u></p> <p><b>Telephone Number:</b> <u>( 847 ) 329-1555</u> Fax # <u>( 847 ) 329-9555</u></p> <p><b>IDPA ID Number:</b> <u>36-4303161</u></p> <p><b>Date of Initial License for Current Owners:</b> <u>11/01/99</u></p> <p><b>Type of Ownership:</b></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><b>IRS Exemption Code</b> _____</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><b>In the event there are further questions about this report, please contact:</b>  <b>Name:</b> <u>BOB KAGDA</u> <b>Telephone Number:</b> <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	<b>IRS Exemption Code</b> _____	<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><b>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</b></p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/2005</u> to <u>12/31/2005</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 rowspan="3" style="width: 15%;"><b>Officer or Administrator of Provider</b></td> <td>(Signed) _____</td> </tr> <tr> <td>(Type or Print Name) <u>SHERWIN I. RAY</u></td> </tr> <tr> <td>(Title) <u>MANAGER</u></td> </tr> <tr> <td rowspan="5"><b>Paid Preparer</b></td> <td>(Signed) <u>(SEE ATTACHED ACCOUNTANTS' REPORT)</u></td> </tr> <tr> <td>(Date) _____</td> </tr> <tr> <td>(Print Name and Title) <u>BOB KAGDA</u> <u>VICE PRESIDENT</u></td> </tr> <tr> <td>(Firm Name &amp; Address) <u>KRUPNICK, BOKOR, KAGDA &amp; BROOKS, LTD</u> <u>3750 W DEVON, LINCOLNWOOD, IL 60712-1124</u></td> </tr> <tr> <td>(Telephone) <u>( 847 ) 675-3585</u> Fax # <u>( 847 ) 675-5777</u></td> </tr> </table> <p align="right">MAIL TO: BUREAU OF HEALTH FINANCE        ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES        201 S. Grand Avenue East        Springfield, IL 62763-0001 Phone # (217) 782-1630</p>	<b>Officer or Administrator of Provider</b>	(Signed) _____	(Type or Print Name) <u>SHERWIN I. RAY</u>	(Title) <u>MANAGER</u>	<b>Paid Preparer</b>	(Signed) <u>(SEE ATTACHED ACCOUNTANTS' REPORT)</u>	(Date) _____	(Print Name and Title) <u>BOB KAGDA</u> <u>VICE PRESIDENT</u>	(Firm Name & Address) <u>KRUPNICK, BOKOR, KAGDA &amp; BROOKS, LTD</u> <u>3750 W DEVON, LINCOLNWOOD, IL 60712-1124</u>	(Telephone) <u>( 847 ) 675-3585</u> Fax # <u>( 847 ) 675-5777</u>
<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																																	
<b>IRS Exemption Code</b> _____	<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 _____																																		
<b>Officer or Administrator of Provider</b>	(Signed) _____																																		
	(Type or Print Name) <u>SHERWIN I. RAY</u>																																		
	(Title) <u>MANAGER</u>																																		
<b>Paid Preparer</b>	(Signed) <u>(SEE ATTACHED ACCOUNTANTS' REPORT)</u>																																		
	(Date) _____																																		
	(Print Name and Title) <u>BOB KAGDA</u> <u>VICE PRESIDENT</u>																																		
	(Firm Name & Address) <u>KRUPNICK, BOKOR, KAGDA &amp; BROOKS, LTD</u> <u>3750 W DEVON, LINCOLNWOOD, IL 60712-1124</u>																																		
	(Telephone) <u>( 847 ) 675-3585</u> Fax # <u>( 847 ) 675-5777</u>																																		

Facility Name & ID Number OAK PARK HEALTHCARE CENTER

# 0044602 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

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	176	Skilled (SNF)	176	64,240	1
2		Skilled Pediatric (SNF/PED)			2
3	28	Intermediate (ICF)	28	10,220	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	204	TOTALS	204	74,460	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	1,469		2,223	3,692	8
9	SNF/PED					9
10	ICF	32,268	479		32,747	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	33,737	479	2,223	36,439	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 48.94%

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

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

NONE

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

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

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

I. On what date did you start providing long term care at this location?  
Date started 11/01/99

J. Was the facility purchased or leased after January 1, 1978?  
YES  Date 11/01/99 NO

K. Was the facility certified for Medicare during the reporting year?  
YES  NO  If YES, enter number of beds certified 32 and days of care provided 2,223

Medicare Intermediary ADMINASTAR

IV. ACCOUNTING BASIS

ACCRAUAL  MODIFIED CASH\*  CASH\*

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

Tax Year: 12/31/2005 Fiscal Year: 12/31/2005

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

Facility Name & ID Number **OAK PARK HEALTHCARE CENTER** # **0044602** Report Period Beginning: **01/01/2005** Ending: **12/31/2005**

**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
	<b>A. General Services</b>										
1	Dietary	181,333	20,523	14,670	216,526		216,526		216,526		1
2	Food Purchase		166,317		166,317	(15,111)	151,206	(188)	151,018		2
3	Housekeeping	117,254	28,305		145,559		145,559		145,559		3
4	Laundry	69,577	12,666		82,243		82,243		82,243		4
5	Heat and Other Utilities			180,276	180,276		180,276	38	180,314		5
6	Maintenance	42,140	28,011	32,749	102,900		102,900	5,141	108,041		6
7	Other (specify):*			10,296	10,296		10,296	29	10,325		7
8	<b>TOTAL General Services</b>	<b>410,304</b>	<b>255,822</b>	<b>237,991</b>	<b>904,117</b>	<b>(15,111)</b>	<b>889,006</b>	<b>5,020</b>	<b>894,026</b>		<b>8</b>
	<b>B. Health Care and Programs</b>										
9	Medical Director			6,000	6,000		6,000		6,000		9
10	Nursing and Medical Records	1,353,466	57,106	6,740	1,417,312		1,417,312	22,913	1,440,225		10
10a	Therapy	62,114	5,601	79,955	147,670		147,670	(1,007)	146,663		10a
11	Activities	66,990	16,612		83,602		83,602		83,602		11
12	Social Services	110,186		2,544	112,730		112,730		112,730		12
13	CNA Training										13
14	Program Transportation			25	25		25		25		14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	<b>1,592,756</b>	<b>79,319</b>	<b>95,264</b>	<b>1,767,339</b>		<b>1,767,339</b>	<b>21,906</b>	<b>1,789,245</b>		<b>16</b>
	<b>C. General Administration</b>										
17	Administrative	114,360			114,360		114,360	71,823	186,183		17
18	Directors Fees										18
19	Professional Services			271,593	271,593		271,593	(208,581)	63,012		19
20	Dues, Fees, Subscriptions & Promotions			41,894	41,894		41,894	(15,874)	26,020		20
21	Clerical & General Office Expenses	76,824	10,695	342,816	430,335		430,335	(291,877)	138,458		21
22	Employee Benefits & Payroll Taxes			400,929	400,929	15,111	416,040		416,040		22
23	Inservice Training & Education			1,207	1,207		1,207	991	2,198		23
24	Travel and Seminar							192	192		24
25	Other Admin. Staff Transportation			4,504	4,504		4,504	2,198	6,702		25
26	Insurance-Prop.Liab.Malpractice			95,358	95,358		95,358	1,115	96,473		26
27	Other (specify):*							43,155	43,155		27
28	<b>TOTAL General Administration</b>	<b>191,184</b>	<b>10,695</b>	<b>1,158,301</b>	<b>1,360,180</b>	<b>15,111</b>	<b>1,375,291</b>	<b>(396,858)</b>	<b>978,433</b>		<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	<b>2,194,244</b>	<b>345,836</b>	<b>1,491,556</b>	<b>4,031,636</b>		<b>4,031,636</b>	<b>(369,932)</b>	<b>3,661,704</b>		<b>29</b>

\*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	<b>DIETARY</b>		
	DIETITIAN CONSULTANT	XVIII B 35-2	9,787
	REPAIRS & MAINTENANCE		4,883
			0
			14,670
3	<b>HOUSEKEEPING</b>		
			0
			0
			0
4	<b>LAUNDRY</b>		
	EQUIPMENT REPAIRS & MAINTENANCE		0
			0
			0
5	<b>HEAT &amp; OTHER UTILITIES</b>		
	GAS HEAT		73,869
	ELECTRICITY		49,332
	WATER		57,075
	CABLE TV - LOBBY		0
			0
			180,276
6	<b>MAINTENANCE</b>		
	GROUNDS MAINTENANCE		3,718
	PAINTING & DECORATING		108
	BUILDING REPAIRS		0
	MAINTENANCE TRAVEL		0
	EQUIPMENT MAINTENANCE & REPAIR		15,772
	ELEVATOR MAINTENANCE & REPAIR		5,848
	OUTSIDE LABOR		0
	EXTERMINATING SERVICE		3,022
	FIRE SERVICE		4,281
			0
			0
			0
			32,749
7	<b>OTHER</b>		
	SCAVENGER		10,251
	SECURITY SERVICE		45
			10,296
9	<b>MEDICAL DIRECTOR</b>		
	MEDICAL DIRECTOR FEES	XVIII B 36-2	6,000
			6,000

LINE		SCHED REF	TOTAL
10	<b>NURSING</b>		
	CONTRACT NURSING	XVIII C 53-2	
	LABORATORY & XRAY EXPENSE		3,860
	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	1,080
	PHARMACY CONSULTANT	XVIII B 39-2	1,800
	UTILIZATION REVIEW FEES	XVIII B __-2	0
	PHYSICIANS	XVIII B __-2	0
	PSYCHIATRIC	XVIII B 47-2	0
	RN CONSULTANT	XVIII B 38-2	0
	<b>DENTAL SERVICES</b>		0
	<b>MEDICARE &amp; PUBLIC AID CONSULTAN</b>	XVIII B 48-2	0
			6,740
10a	<b>THERAPY</b>		
	PHYSICAL THERAPY SERVICES		4,536
	SPEECH THERAPY SERVICES		54
	OCCUPATIONAL THERAPY SERVICES		1,958
	THERAPY CONTRACT SERVICES		59,007
	PHYSICAL THERAPY CONSULTANT	XVIII B 40-2	7,200
	OCCUPATIONAL THERAPY CONSULTA	XVIII B 41-2	7,200
	RESPIRATORY THERAPY CONSULTAN	XVIII B 42-2	0
	<b>SPEECH THERAPY CONSULTANT</b>	XVIII B 43-2	0
			79,955
11	<b>ACTIVITIES</b>		
	CABLE TV - PATIENT ROOMS		0
	ACTIVITY REHAB CONSULTANT	XVIII B 44-2	0
			0
			0
12	<b>SOCIAL SERVICES</b>		
	SOCIAL REHABILITATION SERVICES		0
	SOCIAL REHABILITATION CONSULTAN	XVIII B 45-2	0
	SOCIAL WORKER	XVIII B 45-2	2,544
			0
			2,544
13	<b>NURSE AIDE TRAINING</b>		
	NURSE AIDE TRAINING COSTS	XIII	0
			0

V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE	SCHED REF	TOTAL
<b>14</b>	<b>PROGRAM TRANSPORTATION</b>	
	PATIENT TRANSPORTATION	25
<b>17</b>	<b>ADMINISTRATIVE</b>	
	MANAGEMENT FEES XIX B	0
<b>18</b>	<b>DIRECTORS FEES</b>	0
<b>19</b>	<b>PROFESSIONAL SERVICES</b>	
	DATA PROCESSING XIX C	28,109
	ADMINISTRATIVE CONSULTANTS XIX C	198,000
	PROFESSIONAL FEES XIX C	45,484
		0
		271,593
<b>20</b>	<b>FEES,SUBSCRIPTIONS,PROMOTIONS</b>	
	ENTERTAINMENT & MARKETING VI 19 XIX F	0
	ADV & PROMO-NON PATIENT RELATED VI 25 XIX F	17,132
	EMPLOYEE WANT ADS XIX F	17,341
	CONTRIBUTIONS VI 20 XIX F	0
	DUES & SUBSCRIPTIONS XIX F	2,866
	LICENSES & PERMITS XIX F	2,973
	PUBLIC RELATIONS-PATIENT RELATED XIX F	0
	ADVERTISING-YELLOW PAGES VI 28 XIX F	455
	TRUST FEES / FRANCHISE TAX / ETC VI 17 XIX F	627
	CONTRIBUTIONS - POLITICAL VI 20 XIX F	500
	HEALTH CARE WORKER BACKGROUND CHEC XIX F	0
		41,894
<b>21</b>	<b>CLERICAL &amp; GENERAL OFFICE EXPENSES</b>	
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)	460
	EQUIPMENT REPAIR & MAINTENANCE	10,184
	OUTSIDE CLERICAL SERVICES	122,400
	PENALTIES / OVERDRAFT CHARGES VI 18	47,988
	HOME OFFICE EXPENSE	143,079
	THEFT & DAMAGE LOSS	87
	TELEPHONE	18,618
	MESSENGER SERVICE	0
		0
		342,816

LINE	SCHED REF	TOTAL
<b>22</b>	<b>EMPLOYEE BENEFITS &amp; PAYROLL TAXES</b>	
	FICA TAXES XIX D	166,754
	UNEMPLOYMENT COMPENSATION XIX D	96,008
	WORKERS COMPENSATION INSURANCE XIX D	63,230
	HOSPITALIZATION INSURANCE XIX D	51,125
	EMPLOYEE BENEFITS - OTHER XIX D	23,812
	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
		400,929
<b>23</b>	<b>INSERVICE TRAINING &amp; EDUCATION</b>	
	EDUCATION & SEMINARS	1,207
		1,207
<b>24</b>	<b>TRAVEL &amp; SEMINARS</b>	
	EDUCATION & SEMINARS XIX G	0
	TRAVEL XIX G	0
		0
		0
		0
<b>25</b>	<b>ADMIN. STAFF TRANSPORTATION</b>	
	TRANSPORTATION - STAFF	4,504
		4,504
<b>26</b>	<b>INSURANCE - PROP. LIAB &amp; MALPRACTICE</b>	
	GENERAL INSURANCE	95,358
		95,358
<b>27</b>	<b>OTHER</b>	
	BAD DEBTS VI 24	0
		0

**GRAND TOTAL COLUMN 3 OTHER** 1,491,556

OAK PARK HEALTHCARE CENTER  
 EMPLOYEE MEAL RECLASSIFICATION (PAGE 3 SCHEDULE V COLUMN 5 LINES 2 AND 22)  
 12/31/2005

TOTAL FOOD PURCHASE	166,317	PATIENT MEALS	109317
LESS SALES TAX	(188)	ADD EMPLOYEE MEALS	10950
-----		-----	
NET FOOD	166,129	TOTAL MEALS/YEAR	120267
TOTAL PATIENT CENSUS	36,439	NET FOOD	166129
TIME 3 MEALS PER DAY	3	DIVIDE TOTAL MEALS/YEAR	120267
-----		-----	
TOTAL PATIENT MEALS	109317	COST PER MEAL	1.38
		TIME EMPLOYEE MEALS	10950
ADD # EMPLOYEE MEALS/DAY	30	-----	
TIME # DAYS	365	EMPLOYEE MEAL RECLASSIFICATION	15111
-----		=====	
TOTAL EMPLOYEE MEALS	10950		

OAK PARK HEALTHCARE CENTER INC EQUIPMENT RENTAL 12/31/05		
VENDOR	DESCRIPTION	AMOUNT
KREG THERAPEUTICS	NURSING EQUIPMENT	\$ 7,960
XCEL SUPPLY	NURSING EQUIPMENT	138
RCS MGMT	NURSING EQUIPMENT	1,010
AIR-SAVER	NURSING EQUIPMENT	1,591
JOHNSON WATER CONDITIONING	PLANT EQUIPMENT	360
FAMILY PRIDE	WASHER/DRYER	9,996
NEOPOST	OFFICE EQUIPMENT	617
GE CAPITAL	COPIER	1,213
TOSHIBA AMERICA	COPIER	1,836
CAREPLUS REHAB	EQUIPMENT/FURNITURE/COMPUTERS	22,117
		-----
		46,836
		=====

OAK PARK HEALTHCARE CENTER INC EDUCATION & SEMINAR 12/31/05						
ACCT #18180						
DATE	INV	SPONSOR	DESCRIPTION	PERSONNEL ATTENDING	LOC	COST
1.05	X	HEALTH ED	IL ELDERLAW 2005	SUZANNE BLANCHARD KARLA ISMAY	IL	278.00
	X	HEALTHCARE INFORMATION	NEW SURVEY GUIDELINES PRESSURE ULCERS	JEFF KALKOWSKI	IL	159.00
	X	C C P SANITATION	FOOD SERVICE SANITATION CERTIFICATION COURSE	ROBERT EULA	IL	450.00
				BOCRDON NATHENIEL SMITH KAMCKIG		
4.05	X	ICLTC	CRISIS MANAGEMENT: LEGAL AND MEDIA RESPONSE	JEFF KALKOWSKI	IL	145.00
9.05		TWAIN KING		DEBORAH FOSTER	IL	175.00
TOTAL						-----
						1,207.00
						=====

OAK PARK HEALTHCARE CENTER INC PROFESSIONAL FEES 12/31/05		
VENDOR	DESCRIPTION	AMOUNT
AMERICAN DATA	DATA PROCESSING	\$ 3,527
ACHIEVE HEALTHCARE	DATA PROCESSING	3,472
E-HEALTH DATA SOLUTIONS	DATA PROCESSING	2,618
NATIONAL DATACARE	DATA PROCESSING	2,917
OMNICARE OF NO IL	DATA PROCESSING	1,175
CAREPLUS MANAGEMENT	DATA PROCESSING	14,400
CAREPLUS MANAGEMENT	ADMINISTRATIV CONSULTANT	198,000
KRUPNICK, BOKOR, KAGDA & BROOKS	ACCOUNTING	28,200
IRA SILVERSTEIN	LEGAL	1,901
MEYER MAGENCE	LEGAL	7,804
PERSONNEL PLANNERS	UC CONSULTANT	2,779
RICHARD PEELO	MEDICARE CONSULTANT	4,800
	TOTAL	271,593

OAK PARK HEALTHCARE CENTER INC TRANSPORTATION - STAFF 12/31/05						
G/L #18370						
	JEFF KALKOWSKI	DARYCE PETTY	DAVID SHIRES	CHERYL GARCIA	TOTAL	
MONTHLY ALLOWANCE	FIELDS	CASH				
*****						
JAN	316.67					316.67
FEB	316.67	31.68		245.66		594.01
MAR	316.67					316.67
APR	319.67					319.67
MAY	316.67					316.67
JUN	316.67					316.67
JUL	316.67					316.67
AUG	316.67					316.67
SEP	316.67					316.67
OCT	316.67		30.00			346.67
NOV	316.67			10.00	250.72	577.39
DEC				450.00		450.00
TOTAL	3,169.70	31.68	30.00	460.00	496.38	4,504.43
=====						
GASOLINE FOR FACILITY BANKING, MAINTENANCE, MARKETING AND ACTIVITIES						

**V. COST CENTER EXPENSES (continued)**

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY	
		Salary/Wage	Supplies	Other	Total					9	10
	D. Ownership	1	2	3	4	5	6	7	8		
30	Depreciation			48,771	48,771		48,771	3,657	52,428		30
31	Amortization of Pre-Op. & Org.										31
32	Interest			486,323	486,323		486,323	38,605	524,928		32
33	Real Estate Taxes			312,082	312,082		312,082		312,082		33
34	Rent-Facility & Grounds			742,694	742,694		742,694		742,694		34
35	Rent-Equipment & Vehicles			46,836	46,836		46,836	(16,981)	29,855		35
36	Other (specify):*										36
37	<b>TOTAL Ownership</b>			1,636,706	1,636,706		1,636,706	25,281	1,661,987		37
	<b>Ancillary Expense</b>										
	<b>E. Special Cost Centers</b>										
38	Medically Necessary Transportation										38
39	Ancillary Service Centers		88,249	80,071	168,320		168,320	(8,518)	159,802		39
40	Barber and Beauty Shops										40
41	Coffee and Gift Shops										41
42	Provider Participation Fee			111,690	111,690		111,690		111,690		42
43	Other (specify):*										43
44	<b>TOTAL Special Cost Centers</b>		88,249	191,761	280,010		280,010	(8,518)	271,492		44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	2,194,244	434,085	3,320,023	5,948,352		5,948,352	(353,169)	5,595,183		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	
	<b>NON-ALLOWABLE EXPENSES</b>	<b>Amount</b>	<b>Refer- ence</b>	<b>OHF USE ONLY</b>	
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	(7,150)	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	(188)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees	(627)	20		17
18	Fines and Penalties	(47,988)	21		18
19	Entertainment				19
20	Contributions	(500)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(17,132)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(455)	20		28
29	Other-Attach Schedule	(38,310)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	<b>\$ (112,350)</b>		<b>\$</b>	<b>30</b>

<b>OHF USE ONLY</b>					
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	
		<b>Amount</b>	<b>Reference</b>	
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)	(240,819)		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	<b>\$ (240,819)</b>		<b>36</b>
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	<b>\$ (353,169)</b>		<b>37</b>

\*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
		<b>Yes</b>	<b>No</b>	<b>Amount</b>	<b>Reference</b>
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	<b>TOTAL (C): (sum of lines 38-46)</b>			<b>\$</b>	<b>47</b>

ID# 0044602

Report Period Beginning: 01/01/2005

Ending: 12/31/2005

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	DEFERRED MAINTENANCE	\$ 264	6	1
2	MARKETING SALARY	(38,574)	21	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	<b>Total</b>	(38,310)		49

## STATE OF ILLINOIS

Summary A

Facility Name &amp; ID Number OAK PARK HEALTHCARE CENTER

# 0044602

Report Period Beginning:

01/01/2005

Ending:

12/31/2005

## 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	(188)	0	0	0	0	0	0	0	0	0	0	(188)	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	38	0	0	0	0	0	0	0	0	0	38	5
6	Maintenance	264	4,877	0	0	0	0	0	0	0	0	0	5,141	6
7	Other (specify):*	0	29	0	0	0	0	0	0	0	0	0	29	7
8	<b>TOTAL General Services</b>	<b>76</b>	<b>4,944</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>5,020</b>	<b>8</b>
	<b>B. Health Care and Programs</b>													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	22,913	0	0	0	0	0	0	0	0	0	22,913	10
10a	Therapy	0	2,192	(3,199)	0	0	0	0	0	0	0	0	(1,007)	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	<b>TOTAL Health Care and Programs</b>	<b>0</b>	<b>25,105</b>	<b>(3,199)</b>	<b>0</b>	<b>21,906</b>	<b>16</b>							
	<b>C. General Administration</b>													
17	Administrative	0	0	71,823	0	0	0	0	0	0	0	0	71,823	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	(212,400)	3,819	0	0	0	0	0	0	0	0	(208,581)	19
20	Fees, Subscriptions & Promotions	(18,714)	0	2,840	0	0	0	0	0	0	0	0	(15,874)	20
21	Clerical & General Office Expenses	(86,562)	(265,479)	60,164	0	0	0	0	0	0	0	0	(291,877)	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	991	0	0	0	0	0	0	0	0	991	23
24	Travel and Seminar	0	0	192	0	0	0	0	0	0	0	0	192	24
25	Other Admin. Staff Transportation	0	0	2,198	0	0	0	0	0	0	0	0	2,198	25
26	Insurance-Prop.Liab.Malpractice	0	0	1,115	0	0	0	0	0	0	0	0	1,115	26
27	Other (specify):*	0	0	43,155	0	0	0	0	0	0	0	0	43,155	27
28	<b>TOTAL General Administration</b>	<b>(105,276)</b>	<b>(477,879)</b>	<b>186,297</b>	<b>0</b>	<b>(396,858)</b>	<b>28</b>							
29	<b>TOTAL Operating Expense</b> (sum of lines 8,16 & 28)	<b>(105,200)</b>	<b>(447,830)</b>	<b>183,098</b>	<b>0</b>	<b>(369,932)</b>	<b>29</b>							

STATE OF ILLINOIS

Summary B

Facility Name & ID Number OAK PARK HEALTHCARE CENTER

# 0044602

Report Period Beginning:

01/01/2005

Ending:

12/31/2005

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	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(7,150)	0	10,807	0	0	0	0	0	0	0	0	3,657	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	38,605	0	0	0	0	0	0	0	0	38,605	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	(16,981)	0	0	0	0	0	0	0	0	(16,981)	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	<b>TOTAL Ownership</b>	<b>(7,150)</b>	<b>0</b>	<b>32,431</b>	<b>0</b>	<b>25,281</b>	<b>37</b>							
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	(8,518)	0	0	0	0	0	0	0	0	(8,518)	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	<b>TOTAL Special Cost Centers</b>	<b>0</b>	<b>0</b>	<b>(8,518)</b>	<b>0</b>	<b>(8,518)</b>	<b>44</b>							
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	<b>(112,350)</b>	<b>(447,830)</b>	<b>207,011</b>	<b>0</b>	<b>(353,169)</b>	<b>45</b>							

**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
				CAREPLUS MGMT	SKOKIE	MGMT/CLERICAL
				CAREPLUS REHABILITATIVE SERVICES		
SEE ATTACHED SCHEDULES					SKOKIE	THERAPY

**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		\$	CAREPLUS MGMT INC		\$		1
2	V	19 ADMIN. CONSULTANT FEES	198,000	" "			(198,000)	2
3	V	19 DATA PROCESSING FEES	14,400	" "			(14,400)	3
4	V	21 CLERICAL FEES	122,400	" "			(122,400)	4
5	V	21 REIMB HOME OFFICE EXPENSE	143,079	" "			(143,079)	5
6	V			" "				6
7	V			" "				7
8	V	5 ELECTRICITY		" "		38	38	8
9	V	6 REPAIRS		" "		1,815	1,815	9
10	V	6 MAINTENANCE SALARIES		" "		3,062	3,062	10
11	V	7 SECURITY		" "		29	29	11
12	V	10 NURSING		" "		22,913	22,913	12
13	V	10a THERAPY SALARIES		" "		2,192	2,192	13
14	Total		\$ 477,879			\$ 30,049	\$ * (447,830)	14

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

Facility Name & ID Number OAK PARK HEALTHCARE CENTER# 0044602Report Period Beginning: 01/01/2005 Ending: 12/31/2005

## VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	17 ADMIN SALARIES	\$	CAREPLUS MGMT INC		\$ 71,823	\$ 71,823
16	V	19 PROFESSIONAL FEES		" "		3,819	3,819
17	V	20 DUES/LICENSES/WANT ADS		" "		2,840	2,840
18	V	21 OFFICE EXPENSES		" "		22,455	22,455
19	V	21 CLERICAL SALARIES		" "		37,709	37,709
20	V	23 SEMINARS		" "		991	991
21	V	24 TRAVEL		" "		192	192
22	V	25 TRANSPORTATION		" "		2,198	2,198
23	V	26 INSURANCE		" "		1,115	1,115
24	V	27 EMPLOYEE BENEFITS		" "		43,155	43,155
25	V	30 SL DEPRECIATION		" "		7,835	7,835
26	V	32 INTEREST		" "		36,819	36,819
27	V	35 EQUIP RENT/AUTO LEASE		" "		5,136	5,136
28	V						
29	V						
30	V	10a THERAPY SERVICES	79,954	CAREPLUS REHABILITATIVE SERVICES		76,755	(3,199)
31	V	39 ANCILLARY THERAPY	84,015	" "		75,497	(8,518)
32	V	35 EQUIPMENT RENT EXPENSE	22,117	" "			(22,117)
33	V	30 SL DEPRECIATION		" "		2,972	2,972
34	V	32 INTEREST		" "		1,786	1,786
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 186,086			\$ 393,097	\$ * 207,011

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

Facility Name & ID Number OAK PARK HEALTHCARE CENTER # 0044602 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

## 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	<b>CAREPLUS MGMT ALLOCATIONS:</b>								\$		1	
2	SHERWIN RAY	PRESIDENT	ADMIN/FINANCE	50.00	SEE ATTACHED	3.9	6.58	SALARY	13,160		17-7	2
3	JAKOB BAKST	DIR OPERAT'NS	ADMIN/CONS.	50.00	SCHEDULES	3.9	6.58	" "	13,160		17-7	3
4												4
5												5
6												6
7												7
8												8
9												9
10												10
11												11
12												12
13								TOTAL	\$ 26,320			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 OAK PARK HEALTHCARE CENTER

# 0044602

Report Period Beginning:

01/01/2005

Ending: 2/31/2005

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 5940 W TOUHY  
 City / State / Zip Code NILES 60714  
 Phone Number ( 847) 647-1717  
 Fax Number ( 847) 647-0222

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		<u>CENSUS DAYS</u>			\$	\$		\$	1
2	<u>5</u>	<u>ELECTRICITY</u>	<u>553,765</u>	<u>13 FACILITIES</u>	<u>574</u>		<u>36,439</u>	<u>38</u>	2
3	<u>6</u>	<u>REPAIRS</u>	<u>553,765</u>	<u>13 FACILITIES</u>	<u>27,588</u>		<u>36,439</u>	<u>1,815</u>	3
4	<u>6</u>	<u>MAINTENANCE SALARIES</u>	<u>553,765</u>	<u>13 FACILITIES</u>	<u>46,540</u>	<u>46,540</u>	<u>36,439</u>	<u>3,062</u>	4
5	<u>7</u>	<u>SECURITY</u>	<u>553,765</u>	<u>13 FACILITIES</u>	<u>444</u>		<u>36,439</u>	<u>29</u>	5
6	<u>10</u>	<u>NURSING</u>	<u>553,765</u>	<u>13 FACILITIES</u>	<u>348,203</u>	<u>348,203</u>	<u>36,439</u>	<u>22,913</u>	6
7	<u>10a</u>	<u>THERAPY SALARIES</u>	<u>553,765</u>	<u>13 FACILITIES</u>	<u>33,317</u>	<u>33,317</u>	<u>36,439</u>	<u>2,192</u>	7
8	<u>17</u>	<u>ADMIN SALARIES</u>	<u>553,765</u>	<u>13 FACILITIES</u>	<u>1,091,504</u>	<u>1,091,504</u>	<u>36,439</u>	<u>71,823</u>	8
9	<u>19</u>	<u>PROFESSIONAL FEES</u>	<u>553,765</u>	<u>13 FACILITIES</u>	<u>58,031</u>		<u>36,439</u>	<u>3,819</u>	9
10	<u>20</u>	<u>DUES/LICENSES/WANT ADS</u>	<u>553,765</u>	<u>13 FACILITIES</u>	<u>43,163</u>		<u>36,439</u>	<u>2,840</u>	10
11	<u>21</u>	<u>OFFICE EXPENSES</u>	<u>553,765</u>	<u>13 FACILITIES</u>	<u>341,243</u>		<u>36,439</u>	<u>22,455</u>	11
12	<u>21</u>	<u>CLERICAL SALARIES</u>	<u>553,765</u>	<u>13 FACILITIES</u>	<u>573,059</u>	<u>573,059</u>	<u>36,439</u>	<u>37,709</u>	12
13	<u>23</u>	<u>SEMINARS</u>	<u>553,765</u>	<u>13 FACILITIES</u>	<u>15,061</u>		<u>36,439</u>	<u>991</u>	13
14	<u>24</u>	<u>TRAVEL</u>	<u>553,765</u>	<u>13 FACILITIES</u>	<u>2,923</u>		<u>36,439</u>	<u>192</u>	14
15	<u>25</u>	<u>TRANSPORTATION</u>	<u>553,765</u>	<u>13 FACILITIES</u>	<u>33,401</u>		<u>36,439</u>	<u>2,198</u>	15
16	<u>26</u>	<u>INSURANCE</u>	<u>553,765</u>	<u>13 FACILITIES</u>	<u>16,951</u>		<u>36,439</u>	<u>1,115</u>	16
17	<u>27</u>	<u>EMPLOYEE BENEFITS</u>	<u>553,765</u>	<u>13 FACILITIES</u>	<u>655,825</u>		<u>36,439</u>	<u>43,155</u>	17
18	<u>30</u>	<u>SL DEPRECIATION</u>	<u>553,765</u>	<u>13 FACILITIES</u>	<u>119,076</u>		<u>36,439</u>	<u>7,835</u>	18
19	<u>32</u>	<u>INTEREST</u>	<u>553,765</u>	<u>13 FACILITIES</u>	<u>559,538</u>		<u>36,439</u>	<u>36,819</u>	19
20	<u>35</u>	<u>EQUIP RENT/AUTO LEASE</u>	<u>553,765</u>	<u>13 FACILITIES</u>	<u>78,057</u>		<u>36,439</u>	<u>5,136</u>	20
21									21
22									22
23									23
24									24
25	<b>TOTALS</b>				\$ <b>4,044,498</b>	\$ <b>2,092,623</b>		\$ <b>266,136</b>	25

Facility Name & ID Number

OAK PARK HEALTHCARE CENTER

# 0044602

Report Period Beginning:

01/01/2005

Ending:

12/31/2005

**IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE**

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

1	2	3	4	5	6	7	8	9	10											
										Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
											YES	NO				Original	Balance			
<b>A. Directly Facility Related</b>																				
<b>Long-Term</b>																				
1	CAREPLUS MANAGEMENT ALLOCATION: LOC, ETC				\$	\$			\$ 36,819	1										
2	CAREPLUS REHAB ALLOCATION: EQUIPMENT LOANS								1,786	2										
3										3										
4										4										
5	CAREPLUS MGMT - CIB BK	X	CAPITAL IMPROVEMENT	\$5,572.35	01/04	234,551	186,135	01/09	PRIME+	66,868	5									
<b>Working Capital</b>																				
6	CAREPLUS MGMT - HFG	X	WORKING CAPITAL	DEMAND	Nov-99	1,925,000	6,087,542		PRIME+	419,455	6									
7										7										
8										8										
9	<b>TOTAL Facility Related</b>			\$5,572.35		\$ 2,159,551	\$ 6,273,677			\$ 524,928	9									
<b>B. Non-Facility Related*</b>																				
10										10										
11										11										
12										12										
13										13										
14	<b>TOTAL Non-Facility Related</b>					\$	\$			\$	14									
15	<b>TOTALS (line 9+line14)</b>					\$ 2,159,551	\$ 6,273,677			\$ 524,928	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 2004 report.		\$	<b>272,650</b>	<b>1</b>
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.)		\$	<b>290,912</b>	<b>2</b>
3. Under or (over) accrual (line 2 minus line 1).		\$	<b>18,262</b>	<b>3</b>
4. Real Estate Tax accrual used for 2005 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	<b>293,820</b>	<b>4</b>
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. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>		\$		<b>5</b>
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. <b>TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>		\$		<b>6</b>
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	<b>312,082</b>	<b>7</b>

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	<b>2000</b>	<b>295,825</b>	<b>8</b>
	<b>2001</b>	<b>324,378</b>	<b>9</b>
	<b>2002</b>	<b>274,833</b>	<b>10</b>
	<b>2003</b>	<b>269,947</b>	<b>11</b>
	<b>2004</b>	<b>290,912</b>	<b>12</b>

**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 2004 TAX BILL.**

<b>FOR OHF USE ONLY</b>			
<b>13</b>	FROM R. E. TAX STATEMENT FOR 2004	\$	<b>13</b>
<b>14</b>	PLUS APPEAL COST FROM LINE 5	\$	<b>14</b>
<b>15</b>	LESS REFUND FROM LINE 6	\$	<b>15</b>
<b>16</b>	AMOUNT TO USE FOR RATE CALCULATION	\$	<b>16</b>

**NOTES:**

- Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
- 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:** 2004 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 2004 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2004.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2004 real estate tax bill to the Department of Public Aid, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

**Please send these items in with your completed 2005 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 Bureau of Health Finance at (217) 782-1630.

**2004 LONG TERM CARE REAL ESTATE TAX STATEMENT**

FACILITY NAME OAK PARK HEALTHCARE CENTER COUNTY COOK

FACILITY IDPH LICENSE NUMBER 0044602

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 2004 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 2004.

(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>16-07-106-004-0000</u>	<u>NURSING HOME</u>	\$ <u>57,999.74</u>	\$ <u>57,999.74</u>
2. <u>16-07-106-005-0000</u>	<u>NURSING HOME</u>	\$ <u>55,499.28</u>	\$ <u>55,499.28</u>
3. <u>16-07-106-022-0000</u>	<u>NURSING HOME</u>	\$ <u>177,413.33</u>	\$ <u>177,413.33</u>
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
	<b>TOTALS</b>	\$ <u>290,912.35</u>	\$ <u>290,912.35</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 2004 tax bills which were listed in Section A to this statement. Be sure to use the 2004 tax bill which is normally paid during 2005.

Facility Name & ID Number OAK PARK HEALTHCARE CENTER

# 0044602

Report Period Beginning:

01/01/2005 Ending:

12/31/2005

**X. BUILDING AND GENERAL INFORMATION:**

A. Square Feet: 52,926 B. General Construction Type: Exterior BRICK Frame STEEL Number of Stories 2+BASEMENT/ 3

C. Does the Operating Entity?  (a) Own the Facility  (b) Rent from a Related Organization.  (c) Rent from Completely Unrelated Organization.  
 (Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity?  (a) Own the Equipment  (b) Rent equipment from a Related Organization.  (c) Rent equipment from Completely Unrelated Organization.  
 (Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

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

---

---

---

---

---

---

---

---

---

---

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>22,950</u>		\$	<u>1</u>
2					<u>2</u>
3	<b>TOTALS</b>	<b>22,950</b>		\$	<b>3</b>

Facility Name &amp; ID Number OAK PARK HEALTHCARE CENTER

# 0044602

Report Period Beginning:

01/01/2005 Ending: 12/31/2005

**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											5
6											6
7											7
8											8
	<b>Improvement Type**</b>										
9		NEW WINDOWS / LIGHT FIXTURES / GENERATOR		1999	74,653	1,914	39	1,914		11,579	9
10		WINDOWS / FENCE / CEILING		2000	13,360	486	27.5	486		2,896	10
11		WINDOWS / SIGNS / FLOORING / WALLPAPER		2000	42,672	1,552	27.5	1,552		9,091	11
12		WINDOWS / FLOORING / WALLPAPER / NURSE STATION		2000	29,709	1,080	27.5	1,080		6,165	12
13		FLOORING / DOORS / WALLS / HVAC SYSTEM		2000	56,310	2,047	27.5	2,047		11,515	13
14		WINDOWS / FLOORING / RAILS / ASPHALT PAVING		2000	30,160	1,096	27.5	1,096		6,034	14
15		WINDOWS / PLUMBING / PAINTING & DECORATING		2000	41,459	1,508	27.5	1,508		7,928	15
16		WINDOW TREATMENTS		2000	15,445	1,378	15	1,030	(348)	5,665	16
17		WINDOWS/WALK-IN FREEZER, ROOF & A/C REPAIRS		2001	23,850	868	27.5	868		4,064	17
18		WINDOWS//FLOORING/ALARM & PAGING SYSTEM		2001	9,926	361	27.5	361		1,482	18
19		WINDOWS/DOORS/GREASE TRAP/ROOF A/C		2002	62,212	2,266	27.5	2,266		7,937	19
20		WINDOWS/BACKFLOW PREVENTORS/AC TOWER BEARING		2003	16,526	603	27.5	603		1,664	20
21		CIRCUITS/ROOFTOP A/C MOTORS		2004	3,382	123	27.5	123		201	21
22		WINDOWS		2004	7,200	262	27.5	262		326	22
23		REMODEL MOLDINGS/HANDRAILS/CABINETRY/DECOR		2004	68,233	2,480	27.5	2,480		3,149	23
24		BUILDING REMODEL PROJECT		2005	486,083	5,202	27.5	5,202		5,202	24
25		LANDSCAPING		2005	16,610	553	15	553		553	25
26											26
27											27
28											28
29											29
30		RELATED PARTY ALLOCATION - CAREPLUS REHAB									30
31		DOORS		2004	4,150	106	39	106		208	31
32											32
33											33
34		RELATED PARTY ALLOCATION - CAREPLUS MGMT									34
35		BUILDING-TAG-18 PROPERTIES		2004	41,189	1,056	39	1,056			35
36		BUILDING IMPROVEMENTS-TAG-18 PROPERTIES		2004	16,182	623	39	623			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.

**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	<b>TOTAL (lines 4 thru 69)</b>	\$	\$ <b>1,059,311</b>		\$ <b>25,564</b>	\$ <b>25,216</b>	\$ <b>(348)</b>	\$ <b>85,659</b>	<b>70</b>

\*\*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	\$ 126,055	\$ 10,394	\$ 13,455	\$ 3,061	8-15 YRS	\$ 57,953	71
72	Current Year Purchases	129,945	14,598	4,735	(9,863)	8-15 YRS	4,735	72
73	Fully Depreciated Assets							73
74	** RELATED PARTY - SL DEPN: CAREPLUS MGMT 6156, CAREPLUS REHAB 2866		9,022	9,022		8-15 YRS		74
75	<b>TOTALS</b>	\$ 256,000	\$ 34,014	\$ 27,212	\$ (6,802)		\$ 62,688	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	<b>TOTALS</b>			\$	\$	\$	\$		\$	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)	\$ 1,315,311	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 59,578	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 52,428	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (7,150)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 148,347	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	<b>TOTALS</b>	\$	\$	\$	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: **FAIRMOUNT OF OAK PARK LLC**

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:	204	11/01/99	\$ 742,694			3
4	Additions						4
5							5
6							6
7	<b>TOTAL</b>	204		\$ 742,694			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: \$ **46,836** 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	<b>TOTAL</b>		\$	\$	21

10. Effective dates of current rental agreement:

Beginning 11/01/99

Ending \_\_\_\_\_

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

Fiscal Year Ending Annual Rent

12. /2006 \$ \_\_\_\_\_

13. /2007 \$ \_\_\_\_\_

14. /2008 \$ \_\_\_\_\_

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

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

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

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

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. <u>CLASSROOM PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
<p><b>THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES</b></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	CNA Competency Tests				
9	<b>TOTALS</b>	\$	\$	\$	\$
10	<b>SUM OF line 9, col. 1 and 2 (e)</b>	\$			

**C. CONTRACTUAL INCOME**

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

\$

**D. NUMBER OF CNAs TRAINED**

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

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

- (e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
- (f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

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

	Service	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	\$		\$ 30,884	\$		\$ 30,884	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			743			743	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			47,728			47,728	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				52,616		52,616	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program	39-2/39-3				716	33,766		34,482	12
13	MED.SUPPLIES/LAB/RENTALS Other (specify):	39-2					1,867		1,867	13
14	<b>TOTAL</b>			\$		\$ 80,071	\$ 88,249		\$ 168,320	14

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

Facility Name &amp; ID Number OAK PARK HEALTHCARE CENTER

# 0044602

Report Period Beginning: 01/01/2005

Ending:

12/31/2005

## XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2005

(last day of reporting year)

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

		1	2	
		Operating	After	
			Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 30,882	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 115,000 )	1,726,203		3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	109,389		6
7	Other Prepaid Expenses	58,418		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): R.E,TAX ESCROW	216,212		9
10	<b>TOTAL Current Assets</b> (sum of lines 1 thru 9)	\$ 2,141,104	\$	10
	<b>B. Long-Term Assets</b>			
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	982,902		15
16	Equipment, at Historical Cost	270,887		16
17	Accumulated Depreciation (book methods)	(217,488)		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): DUE FROM LLC	10,484		23
24	<b>TOTAL Long-Term Assets</b> (sum of lines 11 thru 23)	\$ 1,046,785	\$	24
25	<b>TOTAL ASSETS</b> (sum of lines 10 and 24)	\$ 3,187,889	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 812,120	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	27,678		28
29	Short-Term Notes Payable	6,087,542		29
30	Accrued Salaries Payable	88,965		30
31	Accrued Taxes Payable (excluding real estate taxes)	17,604		31
32	Accrued Real Estate Taxes(Sch.IX-B)	293,820		32
33	Accrued Interest Payable	27,582		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36				36
37				37
38	<b>TOTAL Current Liabilities</b> (sum of lines 26 thru 37)	\$ 7,355,311	\$	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable	186,135		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43				43
44				44
45	<b>TOTAL Long-Term Liabilities</b> (sum of lines 39 thru 44)	\$ 186,135	\$	45
46	<b>TOTAL LIABILITIES</b> (sum of lines 38 and 45)	\$ 7,541,446	\$	46
47	<b>TOTAL EQUITY</b> (page 18, line 24)	\$ (4,353,557)	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY</b> (sum of lines 46 and 47)	\$ 3,187,889	\$	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1 Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>(2,741,658)</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>	<b>POST-CLOSING DEPRECIATION ADJ</b>	<b>1,223</b>	<b>3</b>
<b>4</b>	<b>BAD DEBTS</b>	<b>(63,195)</b>	<b>4</b>
<b>5</b>	<b>ROUNDING</b>	<b>1</b>	<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>(2,803,629)</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>(1,549,928)</b>	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	( )	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ <b>(1,549,928)</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>(4,353,557)</b>	<b>24</b> *

\* 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	
	<b>A. Inpatient Care</b>		
1	Gross Revenue -- All Levels of Care	\$ 4,398,424	1
2	Discounts and Allowances for all Levels	( )	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 4,398,424	3
	<b>B. Ancillary Revenue</b>		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$	8
	<b>C. Other Operating Revenue</b>		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$	23
	<b>D. Non-Operating Revenue</b>		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$	26
	<b>E. Other Revenue (specify):****</b>		
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28			28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 4,398,424	30

2

	Expenses	Amount	
	<b>A. Operating Expenses</b>		
31	General Services	904,117	31
32	Health Care	1,767,339	32
33	General Administration	1,360,180	33
	<b>B. Capital Expense</b>		
34	Ownership	1,636,706	34
	<b>C. Ancillary Expense</b>		
35	Special Cost Centers	168,320	35
36	Provider Participation Fee	111,690	36
	<b>D. Other Expenses (specify):</b>		
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 5,948,352	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	(1,549,928)	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ (1,549,928)	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 **OAK PARK HEALTHCARE CENTER**

# 0044602

Report Period Beginning: 01/01/2005

Ending:

12/31/2005

**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	1,998	2,054	\$ 68,311	\$ 33.26	1
2	Assistant Director of Nursing	1,885	2,042	60,294	29.53	2
3	Registered Nurses	7,744	8,420	220,932	26.24	3
4	Licensed Practical Nurses	14,601	15,509	346,636	22.35	4
5	CNAs & Orderlies	56,586	63,160	636,024	10.07	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	5,800	6,403	62,114	9.70	8
9	Activity Director	1,947	2,223	22,721	10.22	9
10	Activity Assistants	4,833	5,353	44,269	8.27	10
11	Social Service Workers	5,221	5,819	110,186	18.94	11
12	Dietician					12
13	Food Service Supervisor	2,027	2,230	32,810	14.71	13
14	Head Cook	4,605	5,202	56,184	10.80	14
15	Cook Helpers/Assistants	10,601	11,499	92,339	8.03	15
16	Dishwashers					16
17	Maintenance Workers	3,399	3,876	42,140	10.87	17
18	Housekeepers	11,208	12,566	117,254	9.33	18
19	Laundry	7,035	7,818	69,577	8.90	19
20	Administrator	1,927	2,165	85,543	39.51	20
21	Assistant Administrator	1,118	1,309	28,817	22.01	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	4,082	4,371	38,250	8.75	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,928	2,138	21,269	9.95	31
32	Other Health Care(specify)					32
33	Other(specify) <u>MARKETING</u>	1,212	1,330	38,574	29.00	33
34	TOTAL (lines 1 - 33)	149,757	165,487	\$ 2,194,244 *	\$ 13.26	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	\$ 9,787	1-3	35
36	Medical Director	O	6,000	9-3	36
37	Medical Records Consultant	N	1,080	10-3	37
38	Nurse Consultant	T	0	10-3	38
39	Pharmacist Consultant	H	1,800	10-3	39
40	Physical Therapy Consultant	L	7,200	10a-3	40
41	Occupational Therapy Consultant	Y	7,200	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	2,544	12-3	45
46	Other(specify)	S			46
47	<u>PSYCHIATRIC</u>		0	10-3	47
48	<u>M/C &amp; PA CONSULTING</u>		0	10-3	48
49	TOTAL (lines 35 - 48)		\$ 35,611		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	Certified Nurse Assistants/Aides		0	10-3	52
53	TOTAL (lines 50 - 52)		\$		53



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

(See instructions.)

1	2	3	4	5	6	7	8	9	10	11	12	13														
													Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year									
																	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009	FY2010	
1	<b>PAINT/DECORATING</b>	<b>2002</b>	<b>\$ 1,587</b>	<b>3</b>	<b>\$ 265</b>	<b>\$ 529</b>	<b>\$ 529</b>	<b>\$ 264</b>	\$	\$	\$	\$														
2																										
3																										
4																										
5																										
6																										
7																										
8																										
9																										
10																										
11																										
12																										
13																										
14																										
15																										
16																										
17																										
18																										
19																										
20	<b>TOTALS</b>		<b>\$ 1,587</b>		<b>\$ 265</b>	<b>\$ 529</b>	<b>\$ 529</b>	<b>\$ 264</b>	\$	\$	\$	\$														

Facility Name &amp; ID Number OAK PARK HEALTHCARE CENTER

# 0044602

Report Period Beginning: 01/01/2005

Ending: 12/31/2005

**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? YES
- (2) Are there any dues to nursing home associations included on the cost report? YES  
If YES, give association name and amount. IL ASSOC HEALTHCARE FACIL \$2,856
- (3) Did the nursing home make political contributions or payments to a political action organization? YES If YES, have these costs been properly adjusted out of the cost report? YES
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity? \_\_\_\_\_
- (5) Have you properly capitalized all major repairs and equipment purchases? YES  
What was the average life used for new equipment added during this period? 10 YR
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 429 Line 10-2
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? NO  
If YES, give effective date of lease. \_\_\_\_\_
- (9) Are you presently operating under a sublease agreement? \_\_\_\_\_ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES \_\_\_\_\_ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.  
\_\_\_\_\_
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 111,690  
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? NO If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? YES
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? NO For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 15,111 Has any meal income been offset against related costs? N/A Indicate the amount. \$ \_\_\_\_\_
- (16) Travel and Transportation  
a. Are there costs included for out-of-state travel? NO  
If YES, attach a complete explanation.  
b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such a program during this reporting period. \$ \_\_\_\_\_  
c. What percent of all travel expense relates to transportation of nurses and patients? 5%  
d. Have vehicle usage logs been maintained? NO  
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? NO  
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? YES  
g. Does the facility transport residents to and from day training? NO  
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? NO  
Firm Name: \_\_\_\_\_ 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