

Facility Name & ID Number RIVER PARK HEALTHCARE CENTER

0042549 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	177	Skilled (SNF)	177	64,605	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	177	TOTALS	177	64,605	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			3,896	3,896	8
9	SNF/PED					9
10	ICF	42,674	4,316		46,990	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	42,674	4,316	3,896	50,886	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 78.76%

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 03/06/97

J. Was the facility purchased or leased after January 1, 1978?
YES Date 03/06/97 NO

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 26 and days of care provided 3,896

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 **RIVER PARK HEALTHCARE CENTER** # **0042549** 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
	A. General Services										
1	Dietary	173,394	23,978	12,034	209,406		209,406		209,406		1
2	Food Purchase		228,182		228,182	(15,221)	212,961	(754)	212,207		2
3	Housekeeping	139,434	26,204		165,638		165,638		165,638		3
4	Laundry	67,646	14,729		82,375		82,375		82,375		4
5	Heat and Other Utilities			163,851	163,851		163,851	53	163,904		5
6	Maintenance	52,740	48,471	34,266	135,477		135,477	8,768	144,245		6
7	Other (specify):*			9,266	9,266		9,266	41	9,307		7
8	TOTAL General Services	433,214	341,564	219,417	994,195	(15,221)	978,974	8,108	987,082		8
	B. Health Care and Programs										
9	Medical Director			22,500	22,500		22,500		22,500		9
10	Nursing and Medical Records	1,548,864	78,309	104,996	1,732,169		1,732,169	(68,003)	1,664,166		10
10a	Therapy	159,126	9,219	82,114	250,459		250,459	(1,339)	249,120		10a
11	Activities	84,113	13,944	796	98,853		98,853		98,853		11
12	Social Services	101,279		3,334	104,613		104,613		104,613		12
13	CNA Training										13
14	Program Transportation			604	604		604		604		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,893,382	101,472	214,344	2,209,198		2,209,198	(69,342)	2,139,856		16
	C. General Administration										
17	Administrative	75,740		170,000	245,740		245,740	(25,701)	220,039		17
18	Directors Fees										18
19	Professional Services			226,139	226,139		226,139	(160,975)	65,164		19
20	Dues, Fees, Subscriptions & Promotions			24,162	24,162		24,162	(6,163)	17,999		20
21	Clerical & General Office Expenses	88,535	13,123	266,755	368,413		368,413	(162,929)	205,484		21
22	Employee Benefits & Payroll Taxes			331,373	331,373	15,221	346,594		346,594		22
23	Inservice Training & Education			1,538	1,538		1,538	1,384	2,922		23
24	Travel and Seminar							269	269		24
25	Other Admin. Staff Transportation			4,879	4,879		4,879	3,069	7,948		25
26	Insurance-Prop.Liab.Malpractice			151,723	151,723		151,723	1,558	153,281		26
27	Other (specify):*							60,264	60,264		27
28	TOTAL General Administration	164,275	13,123	1,176,569	1,353,967	15,221	1,369,188	(289,224)	1,079,964		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,490,871	456,159	1,610,330	4,557,360		4,557,360	(350,458)	4,206,902		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	11,722
	REPAIRS & MAINTENANCE		312
			0
			12,034
3	HOUSEKEEPING		
			0
			0
			0
4	LAUNDRY		
	EQUIPMENT REPAIRS & MAINTENANCE		0
			0
			0
5	HEAT & OTHER UTILITIES		
	GAS HEAT		30,390
	ELECTRICITY		96,064
	WATER		21,413
	CABLE TV - LOBBY		15,984
			0
			163,851
6	MAINTENANCE		
	GROUNDS MAINTENANCE		0
	PAINTING & DECORATING		515
	BUILDING REPAIRS		0
	MAINTENANCE TRAVEL		0
	EQUIPMENT MAINTENANCE & REPAIR		9,340
	ELEVATOR MAINTENANCE & REPAIR		11,436
	OUTSIDE LABOR		0
	EXTERMINATING SERVICE		106
	FIRE SERVICE		12,869
			0
			0
			0
			34,266
7	OTHER		
	SCAVENGER		9,266
	SECURITY SERVICE		0
			9,266
9	MEDICAL DIRECTOR		
	MEDICAL DIRECTOR FEES	XVIII B 36-2	22,500
			22,500

LINE		SCHED REF	TOTAL
10	NURSING		
	CONTRACT NURSING	XVIII C 53-2	
	LABORATORY & XRAY EXPENSE		4,425
	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	21
	PHARMACY CONSULTANT	XVIII B 39-2	550
	UTILIZATION REVIEW FEES	XVIII B __-2	0
	PHYSICIANS	XVIII B __-2	0
	PSYCHIATRIC	XVIII B 47-2	50,000
	RN CONSULTANT	XVIII B 38-2	0
	DENTAL SERVICES		0
	MEDICARE & PUBLIC AID CONSULTAN	XVIII B 48-2	50,000
			104,996
10a	THERAPY		
	PHYSICAL THERAPY SERVICES		5,746
	SPEECH THERAPY SERVICES		959
	OCCUPATIONAL THERAPY SERVICES		2,844
	THERAPY CONTRACT SERVICES		53,165
	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	5,000
	SPEECH THERAPY CONSULTANT	XVIII B 43-2	0
			82,114
11	ACTIVITIES		
	CABLE TV - PATIENT ROOMS		0
	ACTIVITY REHAB CONSULTANT	XVIII B 44-2	796
			0
			796
12	SOCIAL SERVICES		
	SOCIAL REHABILITATION SERVICES		0
	SOCIAL REHABILITATION CONSULTAN	XVIII B 45-2	0
	SOCIAL WORKER	XVIII B 45-2	3,334
			0
			3,334
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	604
17	ADMINISTRATIVE	
	MANAGEMENT FEES XIX B	170,000
18	DIRECTORS FEES	0
19	PROFESSIONAL SERVICES	
	DATA PROCESSING XIX C	26,586
	ADMINISTRATIVE CONSULTANTS XIX C	162,000
	PROFESSIONAL FEES XIX C	37,553
		0
		226,139
20	FEES,SUBSCRIPTIONS,PROMOTIONS	
	ENTERTAINMENT & MARKETING VI 19 XIX F	0
	ADV & PROMO-NON PATIENT RELATED VI 25 XIX F	9,211
	EMPLOYEE WANT ADS XIX F	10,866
	CONTRIBUTIONS VI 20 XIX F	0
	DUES & SUBSCRIPTIONS XIX F	157
	LICENSES & PERMITS XIX F	3,010
	PUBLIC RELATIONS-PATIENT RELATED XIX F	0
	ADVERTISING-YELLOW PAGES VI 28 XIX F	418
	TRUST FEES / FRANCHISE TAX / ETC VI 17 XIX F	0
	CONTRIBUTIONS - POLITICAL VI 20 XIX F	500
	HEALTH CARE WORKER BACKGROUND CHEC XIX F	0
		24,162
21	CLERICAL & GENERAL OFFICE EXPENSES	
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)	661
	EQUIPMENT REPAIR & MAINTENANCE	3,662
	OUTSIDE CLERICAL SERVICES	106,200
	PENALTIES / OVERDRAFT CHARGES VI 18	44,140
	HOME OFFICE EXPENSE	96,605
	THEFT & DAMAGE LOSS	0
	TELEPHONE	15,487
	MESSENGER SERVICE	0
		0
		266,755

LINE	SCHED REF	TOTAL
22	EMPLOYEE BENEFITS & PAYROLL TAXES	
	FICA TAXES XIX D	186,908
	UNEMPLOYMENT COMPENSATION XIX D	44,924
	WORKERS COMPENSATION INSURANCE XIX D	78,453
	HOSPITALIZATION INSURANCE XIX D	18,851
	EMPLOYEE BENEFITS - OTHER XIX D	2,237
	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
		331,373
23	INSERVICE TRAINING & EDUCATION	
	EDUCATION & SEMINARS	1,538
		1,538
24	TRAVEL & SEMINARS	
	EDUCATION & SEMINARS XIX G	0
	TRAVEL XIX G	0
		0
		0
		0
25	ADMIN. STAFF TRANSPORTATION	
	TRANSPORTATION - STAFF	4,879
		4,879
26	INSURANCE - PROP. LIAB & MALPRACTICE	
	GENERAL INSURANCE	150,236
	SELF-CAP INSURANCE EXPENSES	1,487
		151,723
27	OTHER	
	BAD DEBTS VI 24	0
		0

GRAND TOTAL COLUMN 3 OTHER

1,610,330

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

TOTAL FOOD PURCHASE	228,182	PATIENT MEALS	152658
LESS SALES TAX	(754)	ADD EMPLOYEE MEALS	10950
-----		-----	
NET FOOD	227,428	TOTAL MEALS/YEAR	163608
-----		-----	
TOTAL PATIENT CENSUS	50,886	NET FOOD	227428
TIME 3 MEALS PER DAY	3	DIVIDE TOTAL MEALS/YEAR	163608
-----		-----	
TOTAL PATIENT MEALS	152658	COST PER MEAL	1.39
		TIME EMPLOYEE MEALS	10950
ADD # EMPLOYEE MEALS/DAY	30	-----	
TIME # DAYS	365	EMPLOYEE MEAL RECLASSIFICATION	15221
-----		=====	
TOTAL EMPLOYEE MEALS	10950		

RIVER PARK HEALTHCARE CENTER INC PROFESSIONAL FEES 12/31/05		
VENDOR	DESCRIPTION	AMOUNT
CARE PLUS	DATA PROCESSING	\$ 13,200
ACHIEVE HEALTHCARE	DATA PROCESSING	3,472
AMERICAN DATA	DATA PROCESSING	3,949
NATIONAL DATA CARE	DATA PROCESSING	3,280
e-HEALTH DATA SOLUTIONS	DATA PROCESSING	2,686
CARE PLUS	ADMINISTRATIVE CONSULTANT	162,000
KRUPNICK, BOKOR, KAGDA, LTD	ACCOUNTING	27,600
ABRAHAM A GUTNICKI ESQ	LEGAL	100
MEYER MAGENCE	LEGAL	3,080
SACHNOFF & WEAVER	LEGAL	325
PERSONNEL PLANNER	UC CONSULTANT	1,648
RICHARD PEELO	MEDICARE CONSULTANT	4,800
	TOTAL	226,139

RIVER PARK HEALTHCARE CENTER INC EQUIPMENT RENTAL 12/31/05		
VENDOR	DESCRIPTION	AMOUNT
KCI	NURSING EQUIPMENT	21,204
RCS MANAGEMENT	NURSING EQUIPMENT	1,134
TRINITY HOME CARE	NURSING EQUIPMENT	360
GENESIS/COOK MED	NURSING EQUIPMENT	397
FAMILY PRIDE	WASHER/DRYER	9,300
ECOLAB	DISHWASHER	1,125
GE CAPITAL	COPIER	1,213
U HAUL	TRUCK	146
PITNEY BOWES	POSTAGE METER	919
TOSHIBA AMERICA	COPIER	672
CAREPLUS REHAB	EQUIPMENT/FURNITURE/COMPUTERS	74,467
	TOTAL:	110,934

RIVER PARK HEALTHCARE CENTER INC EDUCATION & SEMINAR 12/31/05						
DATE	INV	SPONSOR OF SEMINAR	PURPOSE OF SEMINAR	PERSONNEL ATTENDING	LOC	COST OF SEMINAR
ACCT #18180						
3.05	X	LTC MANAGEMENT	HOW TO DEVELOP A SUCCESSFUL SAFETY COMMITTEE & EFFECTIVE INCENTIVE PROGRAMS	TAMARA STONEBERGER	IL	100.00
	X	BLACK HAWK COLLEGE	REFRESHER SEMINAR ON FOOD CODES	CHRISTOPHER WELCH	IL	27.00
	X	BLACK HAWK COLLEGE	FOOD SERVICE SANITATION SEMINAR	DONNA SALINAS	IL	78.00
	X	DIETARY MANAGERS ASSN	PROFESSIONAL BOOKS	KATHLEEN CLARK	IL	50.47
	X	ICLT C	NEW CMS REQUIREMENTS FOR PRESSURE ULCERS	CHRISTOPHER WELCH	IL	145.00
	X	CROSS COUNTRY EDUCATION	HEALTH CARE MKTG SKILLS * HOW TO USE THEM: COMMUNICATING YOUR MESSAGE	MIKE MANUEL	IL	169.00
	X	CHRIS WELCH PETTY CASH	MILEAGE REIMBURSEMENT TO SEMINARS	CHRISTOPHER WELCH	IL	120.00
6.05	X	DMA EDUCATION DEPT	A DATE WITH FOOD SAFETY	KATHY CLARK	IL	10.00
	X	IL DEPT OF PUBLIC HEALTH	CERTIFICATION	DONNA SALINAS	IL	35.00
8.05	X	BLACK HAWK COLLEGE	FOOD SERVICE SANITATION COURSE	SLATER SHALORDA	IL	234.00
9.05	X	DIETARY MANAGERS ASSN	DMA PRINTED PUBLICATIONS	KATHY CLARK	IL	69.87
10.05	X	INFORMATION CONTROLS	ON-SITE SOFTWARE TRAINING 4HRS		IL	500.00
TOTAL						1,538.34
						=====

RIVER PARK HEALTHCARE CENTER INC TRANSPORTATION - STAFF 12/31/05	
G/L #18370	
	CHRIS WELCH
	PETTY CASH

JAN	394.82
FEB	359.21
MAR	276.01
APR	744.39
MAY	357.81
JUN	404.21
JUL	251.31
AUG	451.41
SEP	300.16
OCT	635.24
NOV	382.23
DEC	322.55

TOTAL	4,879.35
=====	
GASOLINE FOR FACILITY BANKING MAINTENANCE, MEETINGS, 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			19,770	19,770		19,770	141,599	161,369		30
31	Amortization of Pre-Op. & Org.										31
32	Interest			2,795	2,795		2,795	287,127	289,922		32
33	Real Estate Taxes			149,800	149,800		149,800		149,800		33
34	Rent-Facility & Grounds			447,933	447,933		447,933	(447,933)			34
35	Rent-Equipment & Vehicles			110,934	110,934		110,934	(67,294)	43,640		35
36	Other (specify):*										36
37	TOTAL Ownership			731,232	731,232		731,232	(86,501)	644,731		37
	Ancillary Expense										
	E. Special Cost Centers										
38	Medically Necessary Transportation										38
39	Ancillary Service Centers		178,428	129,687	308,115		308,115	(13,149)	294,966		39
40	Barber and Beauty Shops										40
41	Coffee and Gift Shops										41
42	Provider Participation Fee			96,908	96,908		96,908		96,908		42
43	Other (specify):*										43
44	TOTAL Special Cost Centers		178,428	226,595	405,023		405,023	(13,149)	391,874		44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,490,871	634,587	2,568,157	5,693,615		5,693,615	(450,108)	5,243,507		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 **RIVER PARK HEALTHCARE CENTER**

0042549

Report Period Beginning: **01/01/2005**

Ending: **12/31/2005**

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	3,170	30		9
10	Interest and Other Investment Income	(79,811)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(754)	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				17
18	Fines and Penalties	(44,140)	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	(9,211)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(418)	20		28
29	Other-Attach Schedule DEFERRED MAINT	1,956	6		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (129,708)		\$	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)	(322,042)		34
35	Other- Attach Schedule MAGENCE-LEGAL FI	1,642	19	35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (320,400)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (450,108)		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

RIVER PARK HEALTHCARE CENTER

ID# 0042549

Report Period Beginning: 01/01/2005

Ending: 12/31/2005

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
1	DEFERRED MAINTENANCE	\$ 1,956	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	1,956	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number RIVER PARK HEALTHCARE CENTER# 0042549

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	(754)	0	0	0	0	0	0	0	0	0	0	(754)	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	53	0	0	0	0	0	0	0	0	0	53	5
6	Maintenance	1,956	6,812	0	0	0	0	0	0	0	0	0	8,768	6
7	Other (specify):*	0	41	0	0	0	0	0	0	0	0	0	41	7
8	TOTAL General Services	1,202	6,906	0	0	0	0	0	0	0	0	0	8,108	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	(68,003)	0	0	0	0	0	0	0	0	0	(68,003)	10
10a	Therapy	0	3,062	(4,401)	0	0	0	0	0	0	0	0	(1,339)	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	TOTAL Health Care and Programs	0	(64,941)	(4,401)	0	(69,342)	16							
	C. General Administration													
17	Administrative	0	(126,000)	100,299	0	0	0	0	0	0	0	0	(25,701)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	1,642	(175,200)	12,583	0	0	0	0	0	0	0	0	(160,975)	19
20	Fees, Subscriptions & Promotions	(10,129)	0	3,966	0	0	0	0	0	0	0	0	(6,163)	20
21	Clerical & General Office Expenses	(44,140)	(202,805)	84,016	0	0	0	0	0	0	0	0	(162,929)	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	1,384	0	0	0	0	0	0	0	0	1,384	23
24	Travel and Seminar	0	0	269	0	0	0	0	0	0	0	0	269	24
25	Other Admin. Staff Transportation	0	0	3,069	0	0	0	0	0	0	0	0	3,069	25
26	Insurance-Prop.Liab.Malpractice	0	0	1,558	0	0	0	0	0	0	0	0	1,558	26
27	Other (specify):*	0	0	60,264	0	0	0	0	0	0	0	0	60,264	27
28	TOTAL General Administration	(52,627)	(504,005)	267,408	0	(289,224)	28							
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(51,425)	(562,040)	263,007	0	(350,458)	29							

STATE OF ILLINOIS

Summary B

Facility Name & ID Number RIVER PARK HEALTHCARE CENTER # 0042549 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	3,170	0	138,429	0	0	0	0	0	0	0	0	141,599	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(79,811)	0	366,938	0	0	0	0	0	0	0	0	287,127	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	(447,933)	0	0	0	0	0	0	0	0	(447,933)	34
35	Rent-Equipment & Vehicles	0	0	(67,294)	0	0	0	0	0	0	0	0	(67,294)	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(76,641)	0	(9,860)	0	(86,501)	37							
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	(13,149)	0	0	0	0	0	0	0	0	(13,149)	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	(13,149)	0	(13,149)	44							
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(128,066)	(562,040)	239,998	0	(450,108)	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
				CAREPLUS MGMT	SKOKIE	MGMT/CLERICAL
				CAREPLUS REHABILITATIVE SERVICES		
SEE ATTACHED SCHEDULES					SKOKIE	THERAPY
				RIVER PARK HEALTHCARE CENTER LLC		
					SKOKIE	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:		
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	17	MANAGEMENT FEES	\$ 126,000	CAREPLUS MGMT INC			(126,000)	1
2	V	19	ADMIN. CONSULTANT FEES	162,000	" "			(162,000)	2
3	V	19	DATA PROCESSING FEES	13,200	" "			(13,200)	3
4	V	21	CLERICAL FEES	106,200	" "			(106,200)	4
5	V	21	REIMB HOME OFFICE EXPENSE	96,605	" "			(96,605)	5
6	V	10	M/C,PA,PSYCH FEES	100,000	" "			(100,000)	6
7	V				" "				7
8	V	5	ELECTRICITY		" "		53	53	8
9	V	6	REPAIRS		" "		2,535	2,535	9
10	V	6	MAINTENANCE SALARIES		" "		4,277	4,277	10
11	V	7	SECURITY		" "		41	41	11
12	V	10	NURSING		" "		31,997	31,997	12
13	V	10a	THERAPY SALARIES		" "		3,062	3,062	13
14	Total		\$ 604,005			\$	41,965	\$ * (562,040)	14

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	17 ADMIN SALARIES	\$	CAREPLUS MGMT INC		\$ 100,299	\$ 100,299
16	V	19 PROFESSIONAL FEES		" "		5,333	5,333
17	V	20 DUES/LICENSES/WANT ADS		" "		3,966	3,966
18	V	21 OFFICE EXPENSES		" "		31,357	31,357
19	V	21 CLERICAL SALARIES		" "		52,659	52,659
20	V	23 SEMINARS		" "		1,384	1,384
21	V	24 TRAVEL		" "		269	269
22	V	25 TRANSPORTATION		" "		3,069	3,069
23	V	26 INSURANCE		" "		1,558	1,558
24	V	27 EMPLOYEE BENEFITS		" "		60,264	60,264
25	V	30 SL DEPRECIATION		" "		10,942	10,942
26	V	32 INTEREST		" "		51,416	51,416
27	V	35 EQUIP RENT/AUTO LEASE		" "		7,173	7,173
28	V						
29	V	10a THERAPY SERVICES	77,112	CAREPLUS REHABILITATIVE SERVICES		72,711	(4,401)
30	V	39 ANCILLARY THERAPY	129,686	" "		116,537	(13,149)
31	V	35 EQUIPMENT RENT EXPENSE	74,467	" "			(74,467)
32	V	30 SL DEPRECIATION		" "		10,880	10,880
33	V	32 INTEREST		" "		7,532	7,532
34	V						
35	V	34 RENT	447,933	RIVER PARK HEALTHCARE CENTER LLC			(447,933)
36	V	30 SL DEPRECIATION		" "		116,607	116,607
37	V	32 INTEREST		" "		307,990	307,990
38	V	19 ACCOUNTING FEES		" "		7,250	7,250
39	Total		\$ 729,198			\$ 969,196	\$ * 239,998

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

Facility Name & ID Number RIVER PARK HEALTHCARE CENTER # 0042549 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	2	3	4	5	6		7		8	9	
					Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**				
Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Hours	Percent	Description	Amount	Schedule V. Line & Column Reference		
1	CAREPLUS MGMT ALLOCATIONS:							\$		1	
2	SHERWIN RAY	PRESIDENT	ADMIN/FINANCE	32.02	SEE ATTACHED	5.5	9.19	SALARY	18,378	17-7	2
3	JAKOB BAKST	DIR OPERAT'NS	ADMIN/CONS.	32.02	SCHEDULES	5.5	9.19	" "	18,378	17-7	3
4	JAMEE O'BRIEN	REGIONAL DIR.	ADMIN	1.70	" "	5.5	9.19	" "	11,716	17-7	4
5	JOE ZIMMERMAN	CFO	CLERICAL	1.70	" "	5.5	9.19	" "	11,865	21-7	5
6	BARAK BAVER	OFFICE MANAGER	CLERICAL	0.56	" "	5.5	9.19	" "	6,366	21-7	6
7											7
8											8
9	HUNTER MGMT LLC -- ERIC ROTHNER		MGMT		" "			MGMT FEES	44,000	17-3	9
10											10
11											11
12											12
13								TOTAL	\$ 110,703		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 **RIVER PARK HEALTHCARE CENTER**

0042549

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		CENSUS DAYS			\$	\$		\$	1
2	5	ELECTRICITY	553,765	13 FACILITIES	574		50,886	53	2
3	6	REPAIRS	553,765	13 FACILITIES	27,588		50,886	2,535	3
4	6	MAINTENANCE SALARIES	553,765	13 FACILITIES	46,540	46,540	50,886	4,277	4
5	7	SECURITY	553,765	13 FACILITIES	444		50,886	41	5
6	10	NURSING	553,765	13 FACILITIES	348,203	348,203	50,886	31,997	6
7	10a	THERAPY SALARIES	553,765	13 FACILITIES	33,317	33,317	50,886	3,062	7
8	17	ADMIN SALARIES	553,765	13 FACILITIES	1,091,504	1,091,504	50,886	100,299	8
9	19	PROFESSIONAL FEES	553,765	13 FACILITIES	58,031		50,886	5,333	9
10	20	DUES/LICENSES/WANT ADS	553,765	13 FACILITIES	43,163		50,886	3,966	10
11	21	OFFICE EXPENSES	553,765	13 FACILITIES	341,243		50,886	31,357	11
12	21	CLERICAL SALARIES	553,765	13 FACILITIES	573,059	573,059	50,886	52,659	12
13	23	SEMINARS	553,765	13 FACILITIES	15,061		50,886	1,384	13
14	24	TRAVEL	553,765	13 FACILITIES	2,923		50,886	269	14
15	25	TRANSPORTATION	553,765	13 FACILITIES	33,401		50,886	3,069	15
16	26	INSURANCE	553,765	13 FACILITIES	16,951		50,886	1,558	16
17	27	EMPLOYEE BENEFITS	553,765	13 FACILITIES	655,825		50,886	60,264	17
18	30	SL DEPRECIATION	553,765	13 FACILITIES	119,076		50,886	10,942	18
19	32	INTEREST	553,765	13 FACILITIES	559,538		50,886	51,416	19
20	35	EQUIP RENT/AUTO LEASE	553,765	13 FACILITIES	78,057		50,886	7,173	20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 4,044,498	\$ 2,092,623		\$ 371,654	25

Facility Name & ID Number **RIVER PARK HEALTHCARE CENTER**

0042549

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	Name of Lender	2 Related**		3 Purpose of Loan	4 Monthly Payment Required	5 Date of Note	6 Amount of Note		8 Maturity Date	9 Interest Rate (4 Digits)	10 Reporting Period Interest Expense
		YES	NO				Original	Balance			
A. Directly Facility Related											
Long-Term											
1	RELATED PARTY: PRAIRIE VILLAGE HEALTHCARE CENTER LLC						\$	\$			\$
2	CAMBRIDGE/HEARTLAND		X	MORTGAGE	\$29,195.15	11/03	5,141,900	4,999,461	10/33		276,833
3	LOAN COSTS		X	LOAN COSTS	W/O OVER LOAN	11/03	96,537	87,675			3,218
4	MIP INSURANCE		X	MORTGAGE INSURANCE							25,167
5	CAREPLUS MGMT - CIB BK	X		CAPITAL IMPROVEMENT	\$1,390.84	01/04	58,543	32,541	01/09	PRIME+	2,772
Working Capital											
6	INSURANCE FINANCING		X	INSUR. FINANCE							2,795
7	CAREPLUS MANAGEMENT ALLOCATION: LOC, ETC										51,416
8	CAREPLUS REHAB ALLOCATION: EQUIP LOANS										7,532
9	TOTAL Facility Related				\$30,585.99		\$ 5,296,980	\$ 5,119,677			\$ 369,733
B. Non-Facility Related*											
10											
11											
12											
13											
14	TOTAL Non-Facility Related						\$	\$			\$
15	TOTALS (line 9+line14)						\$ 5,296,980	\$ 5,119,677			\$ 369,733

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 25,167 Line # 32-7

* 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.		\$	137,350	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.)		\$	142,860	2
3. Under or (over) accrual (line 2 minus line 1).		\$	5,510	3
4. Real Estate Tax accrual used for 2005 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	144,290	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.		\$	149,800	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2000	122,973	8
	2001	128,360	9
	2002	133,374	10
	2003	135,986	11
	2004	142,860	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 2004 TAX BILL.

FOR OHF USE ONLY			
13	FROM R. E. TAX STATEMENT FOR 2004	\$	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:

- 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 RIVER PARK HEALTHCARE CENTER COUNTY ROCK ISLAND

FACILITY IDPH LICENSE NUMBER 0042549

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>10-341-78-00</u>	<u>NURSING HOME</u>	\$ <u>1,259.24</u>	\$ <u>1,259.24</u>
2. <u>10-341-79-00</u>	<u>NURSING HOME</u>	\$ <u>141,600.52</u>	\$ <u>141,600.52</u>
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>142,859.76</u>	\$ <u>142,859.76</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 RIVER PARK HEALTHCARE CENTER

0042549

Report Period Beginning:

01/01/2005 Ending:

12/31/2005

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 59,494 B. General Construction Type: Exterior BRICK Frame WOOD Number of Stories 4 + BASEMENT

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:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>RELATED PARTY:PRAIRIE VILLAGE HEALTHCARE CENTER LLC</u>				1
2	<u>NURSING HOME:</u>	<u>5.16 ACRES</u>	<u>1997</u>	<u>420,000</u>	2
3	TOTALS	#VALUE!		\$ 420,000	3

Facility Name & ID Number RIVER PARK HEALTHCARE CENTER

0042549

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	RELATED PARTY: RIVER PARK HEALTHCARE CENTER LLC:			\$	\$		\$	\$	4
5	177	1997	1975	3,596,265	92,208	39	92,208		764,601
6									6
7									7
8									8
	Improvement Type**								
9	FLOORING,WALLCOVER,WINDOW TREATMENTS,DOORS		1997	66,202	1,698	39	1,698		14,669
10	WINDOWS		1998	2,278	58	39	58		435
11	WALK-IN FREEZER COMPRESSOR		2000	2,097	76	27.5	76		447
12	ELECTRICAL WORK		2001	1,854	67	27.5	67		316
13	NEW GREASE TRAP & CHANGEOUT WATER HEATER		2002	10,887	396	27.5	396		1,215
14	DOORS / CABLE INSTALLATION		2003	5,954	216	27.5	216		453
15	KICKBOARDS		2004	9,240	336	27.5	336		518
16	SECURITY SYSTEM / EXHAUST VENTS		2005	36,703	581	27.5	581		581
17	GAZEBO / FENCE		2005	12,057	401	15	401		401
18									18
19									19
20									20
21									21
22	RELATED PARTY: CAREPLUS REHAB								22
23	FIRE CODE REMODELLING		2003	36,915	947	39	947		1,933
24	FIRE CODE REMODELLING		2004	30,078	771	39	771		1,440
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32	RELATED PARTY: CAREPLUS MANAGEMENT:								32
33	BUILDING-TAG-18 PROPERTIES		2004	57,519	1,475	39	1,475		
34	BUILDING IMPROVEMENTS-TAG-18 PROPERTIES		2004	22,597	870	39	870		
35									35
36									36

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

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

See Page 12A, Line 70 for total

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9		
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
37		\$	\$		\$	\$	\$	37	
38								38	
39								39	
40								40	
41								41	
42								42	
43								43	
44								44	
45								45	
46								46	
47								47	
48								48	
49								49	
50								50	
51								51	
52								52	
53								53	
54								54	
55								55	
56								56	
57								57	
58								58	
59								59	
60								60	
61								61	
62								62	
63								63	
64								64	
65								65	
66								66	
67								67	
68								68	
69								69	
70	TOTAL (lines 4 thru 69)	\$	\$ 3,890,646		\$ 100,100	\$	\$ 100,100	\$ 787,009	70

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

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 216,521	\$ 11,289	\$ 17,570	\$ 6,281	8-15 YRS	\$ 109,351	71
72	Current Year Purchases	26,086	5,053	1,815	(3,238)	3-15 YRS	1,815	72
73	Fully Depreciated Assets							73
74	** REL'D PARTY-SL DEPN:CAREPL MGT, 8597/RIVER PK LLC, 22500/REHAB, 9162		40,259	40,259				74
75	TOTALS	\$ 242,607	\$ 56,601	\$ 59,644	\$ 3,043		\$ 111,166	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	FACILITY VAN		2001	\$ 13,000	\$ 1,498	\$ 1,625	\$ 127	4 YRS	\$ 13,000	76
77										77
78										78
79										79
80	TOTALS			\$ 13,000	\$ 1,498	\$ 1,625	\$ 127		\$ 13,000	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)	\$ 4,566,253	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 158,199	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 161,369	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 3,170	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 911,175	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 -- RELATED PARTY

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: \$ 110,934 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			\$	\$ 0	17
18					18
19					19
20					20
21	TOTAL		\$	\$	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. _____ /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>THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES</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	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 CNAs from other facilities.

\$

D. NUMBER OF CNAs TRAINED

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

- (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	\$		\$ 45,153	\$		\$ 45,153	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			13,933			13,933	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			65,714			65,714	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				110,895		110,895	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program	39-2				4,887	52,103		56,990	12
13	MED.SUPPLIES/LAB/RENTALS Other (specify):	39-2					15,430		15,430	13
14	TOTAL			\$		\$ 129,687	\$ 178,428		\$ 308,115	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 & ID Number RIVER PARK HEALTHCARE CENTER

0042549

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*	
	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>20,000</u>)	1,677,709		3
4	Supply Inventory (priced at _____)			4
5	Short-Term Investments	734,366		5
6	Prepaid Insurance	59,027		6
7	Other Prepaid Expenses	101,536		7
8	Accounts Receivable (owners or related parties)	67,810		8
9	Other(specify): _____			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,640,448	\$	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	74,841		15
16	Equipment, at Historical Cost	255,607		16
17	Accumulated Depreciation (book methods)	(219,264)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify): _____			22
23	Other(specify): _____			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 111,184	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,751,632	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 875,929	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	144,810		30
31	Accrued Taxes Payable (excluding real estate taxes)	14,320		31
32	Accrued Real Estate Taxes(Sch.IX-B)	144,290		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)	\$ 1,179,349	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	<u>DUE TO LLC</u>	124,524		43
44	_____			44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 124,524	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,303,873	\$	46
47	TOTAL EQUITY (page 18, line 24)	\$ 1,447,759	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,751,632	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,255,784	1
2	Restatements (describe):		2
3	POST-CLOSING SUPPLIES/EQUIP/DEPRECIATION ADJ	(4,018)	3
4	BAD DEBTS	(68,525)	4
5	ROUNDING	6	5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,183,247	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	264,512	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)	\$ 264,512	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)	\$ 1,447,759	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	\$ 5,879,679	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 5,879,679	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	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	78,448	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 78,448	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)	\$ 5,958,127	30

2

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	994,195	31
32	Health Care	2,209,198	32
33	General Administration	1,353,967	33
	B. Capital Expense		
34	Ownership	731,232	34
	C. Ancillary Expense		
35	Special Cost Centers	308,115	35
36	Provider Participation Fee	96,908	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 5,693,615	40
41	Income before Income Taxes (line 30 minus line 40)**	264,512	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 264,512	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 RIVER PARK HEALTHCARE CENTER

0042549

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	4,044	4,316	\$ 114,196	\$ 26.46	1
2	Assistant Director of Nursing	2,109	2,160	44,902	20.79	2
3	Registered Nurses	5,927	6,195	118,951	19.20	3
4	Licensed Practical Nurses	33,398	35,474	565,101	15.93	4
5	CNAs & Orderlies	67,231	68,305	684,413	10.02	5
6	CNA Trainees					6
7	Licensed Therapist	65	65	1,324	20.37	7
8	Rehab/Therapy Aides	16,185	17,041	157,802	9.26	8
9	Activity Director	1,895	2,082	24,402	11.72	9
10	Activity Assistants	5,894	6,490	59,711	9.20	10
11	Social Service Workers	5,875	6,434	101,279	15.74	11
12	Dietician					12
13	Food Service Supervisor	1,998	2,151	37,109	17.25	13
14	Head Cook	9,788	10,209	83,202	8.15	14
15	Cook Helpers/Assistants	7,795	7,911	53,083	6.71	15
16	Dishwashers					16
17	Maintenance Workers	3,962	4,280	52,740	12.32	17
18	Housekeepers	16,195	17,467	139,434	7.98	18
19	Laundry	8,341	8,877	67,646	7.62	19
20	Administrator	1,883	1,989	67,103	33.74	20
21	Assistant Administrator	349	358	8,637	24.13	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	6,035	6,383	88,535	13.87	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	1,929	2,147	21,301	9.92	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	200,898	210,334	\$ 2,490,871 *	\$ 11.84	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	\$ 11,722	1-3	35
36	Medical Director	O	22,500	9-3	36
37	Medical Records Consultant	N	21	10-3	37
38	Nurse Consultant	T	0	10-3	38
39	Pharmacist Consultant	H	550	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		5,000	10a-3	42
43	Speech Therapy Consultant	F	0	10a-3	43
44	Activity Consultant	E	796	11-3	44
45	Social Service Consultant	E	3,334	12-3	45
46	Other(specify)	S			46
47	PSYCHIATRIC		50,000	10-3	47
48	M/C & PA CONSULTING		50,000	10-3	48
49	TOTAL (lines 35 - 48)		\$ 158,323		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	PAINT/DECORATING	2002	\$ 6,681	3	\$ 1,114	\$ 2,227	\$ 2,227	\$ 1,113	\$	\$	\$	\$														
2	PAINT/DECORATING	2003	2,529	3		422	843	843	421																	
3																										
4																										
5																										
6																										
7																										
8																										
9																										
10																										
11																										
12																										
13																										
14																										
15																										
16																										
17																										
18																										
19																										
20	TOTALS		\$ 9,210		\$ 1,114	\$ 2,649	\$ 3,070	\$ 1,956	\$ 421	\$	\$	\$														

Facility Name & ID Number RIVER PARK HEALTHCARE CENTER

0042549

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? NO
If YES, give association name and amount. _____
- (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. \$ 3,019 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. \$ 96,908
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. \$ 15,221 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