

		FOR BHF USE					

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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.

I. IDPH Facility ID Number: 0036079

Facility Name: Warren Park Nursing Pavilion

Address: 6700 North Damen Avenue Chicago 60645
 Number City Zip Code

County: Cook

Telephone Number: (773) 465-5000 **Fax #** (773) 743-5983

HFS ID Number: 363693973001

Date of Initial License for Current Owners: 03/01/90

Type of Ownership:

<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL
<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State
<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County
IRS Exemption Code _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____
	<input checked="" type="checkbox"/> "Sub-S" Corp.	
	<input type="checkbox"/> Limited Liability Co.	
	<input type="checkbox"/> Trust	
	<input type="checkbox"/> Other _____	

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

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/05 to 12/31/05 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date) _____

(Type or Print Name) _____

(Title) _____

Paid Preparer

(Signed) _____ (Date) _____

(Print Name and Title) Richard S. Sgarlata, C.P.A.

(Firm Name & Address) Frost, Ruttenberg & Rothblatt, P.C.
111 Pfingsten Road, Suite 300 Deerfield, IL 60015

(Telephone) (847) 236-1111 Fax # (847) 236-1155

MAIL TO: BUREAU OF HEALTH FINANCE
 ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
 201 S. Grand Avenue East
 Springfield, IL 62763-0001 Phone # (217) 782-1630

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Warren Park Nursing Pavilion# 0036079 Report Period Beginning: 01/01/05 Ending: 12/31/05

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>127</u>	Skilled (SNF)	<u>127</u>	<u>46,355</u>	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	<u>127</u>	TOTALS	<u>127</u>	<u>46,355</u>	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	<u>4,370</u>	<u>140</u>	<u>1,831</u>	<u>6,341</u>	8
9	SNF/PED					9
10	ICF	<u>24,136</u>	<u>1,402</u>	<u>146</u>	<u>25,684</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>28,506</u>	<u>1,542</u>	<u>1,977</u>	<u>32,025</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 69.09%

D. How many bed-hold days during this year were paid by the Department?

N/A (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)

N/AF. 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 03/10/90

J. Was the facility purchased or leased after January 1, 1978?

YES Date 03/10/90 NO

K. Was the facility certified for Medicare during the reporting year?

YES NO If YES, enter number of beds certified 11 and days of care provided 1,536Medicare Intermediary Mutual Of Omaha

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH* Is your fiscal year identical to your tax year? YES NO Tax Year: 13/31/05 Fiscal Year: 12/31/05

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Warren Park Nursing Pavilion # 0036079 Report Period Beginning: 01/01/05 Ending: 12/31/05

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	208,604	14,828	6,720	230,152		230,152		230,152			1
2	Food Purchase		164,421		164,421	(40,022)	124,399	(79)	124,320			2
3	Housekeeping	103,592	25,136		128,728		128,728		128,728			3
4	Laundry	43,881	7,452		51,333		51,333		51,333			4
5	Heat and Other Utilities			108,633	108,633		108,633	854	109,487			5
6	Maintenance	32,481	13,508	34,920	80,909		80,909	4,612	85,521			6
7	Other (specify):*							465	465			7
8	TOTAL General Services	388,558	225,345	150,273	764,176	(40,022)	724,154	5,852	730,006			8
	B. Health Care and Programs											
9	Medical Director			4,200	4,200		4,200		4,200			9
10	Nursing and Medical Records	886,589	59,224	61,909	1,007,722		1,007,722	(10,422)	997,300			10
10a	Therapy	694		344	1,038		1,038		1,038			10a
11	Activities	63,395	3,194	2,161	68,750		68,750		68,750			11
12	Social Services	90,662		2,493	93,155		93,155		93,155			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,041,340	62,418	71,107	1,174,865		1,174,865	(10,422)	1,164,443			16
	C. General Administration											
17	Administrative	66,636		33,000	99,636		99,636	58,307	157,943			17
18	Directors Fees											18
19	Professional Services			365,064	365,064	(4,188)	360,876	(291,993)	68,883			19
20	Dues, Fees, Subscriptions & Promotions			18,798	18,798		18,798	(7,808)	10,990			20
21	Clerical & General Office Expenses	51,978	747	188,279	241,004		241,004	(113,701)	127,304			21
22	Employee Benefits & Payroll Taxes			258,986	258,986	40,022	299,008	(55)	298,953			22
23	Inservice Training & Education											23
24	Travel and Seminar			1,871	1,871		1,871	71	1,942			24
25	Other Admin. Staff Transportation			12,411	12,411		12,411	771	13,182			25
26	Insurance-Prop.Liab.Malpractice			104,775	104,775		104,775	1,444	106,219			26
27	Other (specify):*							44,645	44,645			27
28	TOTAL General Administration	118,614	747	983,184	1,102,545	35,834	1,138,379	(308,319)	830,061			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,548,512	288,510	1,204,564	3,041,586	(4,188)	3,037,398	(312,889)	2,724,509			29

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Warren Park Nursing Pavilion #0036079 Report Period Beginning: 01/01/05 Ending: 12/31/05

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			34,050	34,050		34,050	171,033	205,083			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			46,411	46,411		46,411	131,220	177,631			32
33	Real Estate Taxes			120,093	120,093	4,188	124,281	(10,029)	114,252			33
34	Rent-Facility & Grounds			376,671	376,671		376,671	(376,671)				34
35	Rent-Equipment & Vehicles			5,526	5,526		5,526	3,817	9,343			35
36	Other (specify):*											36
37	TOTAL Ownership			582,751	582,751	4,188	586,939	(80,630)	506,309			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		41,351	77,926	119,277		119,277	(2,367)	116,910			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			69,533	69,533		69,533		69,533			42
43	Other (specify):*	14,151			14,151		14,151	(14,685)	(534)			43
44	TOTAL Special Cost Centers	14,151	41,351	147,459	202,961		202,961	(17,052)	185,909			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,562,663	329,861	1,934,774	3,827,298		3,827,298	(410,571)	3,416,727			45

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Warren Park Nursing Pavilion

0036079

Report Period Beginning: 01/01/05

Ending: 12/31/05

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	99,923	30		9
10	Interest and Other Investment Income	(17,747)	32		10
11	Discounts, Allowances, Rebates & Refunds	(1,311)	10		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(79)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(24,485)	21		18
19	Entertainment				19
20	Contributions	(750)	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	(107,466)	21		24
25	Fund Raising, Advertising and Promotional	(5,696)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(78,965)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (136,576)		\$	30

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)	(273,995)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (273,995)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (410,571)		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.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

OHF USE ONLY					
48		49		50	51
					52

SEE ACCOUNTANTS' COMPILATION REPORT

Sch. V Line	Amount	Reference
NON-ALLOWABLE EXPENSES		
1	Branch Fee Tax	(41) 21 1
2	Legal	(875) 19 2
3	Trust Fees (Bldg. Co)	(150) 20 3
4	Branch Fee Tax (Bldg. Co)	(250) 20 4
5	Marketing Salary	(14,685) 43 5
6	Marketing	(52,306) 19 6
7	Capitalized R&M	(1,814) 06 7
8	PPA - Patient Settlement	(5,000) 21 8
9	PPA - CMS Facility	(9,003) 21 9
10	Ill. CLTC Copr	(2,014) 20 10
11	Bank Charges	(6,203) 21 11
12	PPA - Maintenance	(280) 06 12
13	PPA - Various Expenses	(830) 21 13
14	PPA - Supplies	(1,764) 10 14
15	PPA - Contract Nursing	(2,999) 10 15
16	PPA - Employee Benefits	(51) 25 16
17	PPA - Equipment	(437) 06 17
18	PPA - Travel Expense	(100) 25 18
19	PPA - Travel Fund	(563) 21 19
20	Non- Allowable Travel	(258) 25 20
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101	Total	(78,988) 101

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Warren Park Nursing Pavilion

0036079

Report Period Beginning:

01/01/05

Ending:

12/31/05

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary													1
2	Food Purchase	(79)											(79)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities			854									854	5
6	Maintenance	(2,601)		2,431	4,782								4,612	6
7	Other (specify):*					465							465	7
8	TOTAL General Services	(2,680)		3,285	4,782	465							5,852	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(5,674)					(4,748)						(10,422)	10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*													15
16	TOTAL Health Care and Programs	(5,674)					(4,748)						(10,422)	16
	C. General Administration													
17	Administrative			(33,000)	91,307								58,307	17
18	Directors Fees													18
19	Professional Services	(32,881)		(259,112)									(291,993)	19
20	Fees, Subscriptions & Promotions	(8,860)	400	652									(7,808)	20
21	Clerical & General Office Expenses	(153,551)		34,595	5,255								(113,701)	21
22	Employee Benefits & Payroll Taxes	(55)											(55)	22
23	Inservice Training & Education													23
24	Travel and Seminar			71									71	24
25	Other Admin. Staff Transportation	(366)		1,137									771	25
26	Insurance-Prop.Liab.Malpractice			1,444									1,444	26
27	Other (specify):*			7,144		37,501							44,645	27
28	TOTAL General Administration	(195,713)	400	(247,069)	96,562	37,501							(308,319)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(204,067)	400	(243,784)	101,344	37,966	(4,748)						(312,889)	29

STATE OF ILLINOIS

Facility Name & ID Number Warren Park Nursing Pavilion

0036079

Report Period Beginning:

01/01/05 Ending:

Summary B

12/31/05

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	99,923	69,199	1,911									171,033	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(17,747)	146,831	2,136									131,220	32
33	Real Estate Taxes		(12,316)	2,287									(10,029)	33
34	Rent-Facility & Grounds		(376,671)										(376,671)	34
35	Rent-Equipment & Vehicles			3,817									3,817	35
36	Other (specify):*													36
37	TOTAL Ownership	82,176	(172,957)	10,151									(80,630)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers						(2,367)						(2,367)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(14,685)											(14,685)	43
44	TOTAL Special Cost Centers	(14,685)					(2,367)						(17,052)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(136,576)	(172,557)	(233,633)	101,344	37,966	(7,115)						(410,571)	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
See Attached		See Attached		See Attached		

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V	34 Rental Income	\$ 376,671	Warren Park LLC		\$	\$ (376,671)	1
2	V	33 Real Estate Tax	121,200	Warren Park LLC			(121,200)	2
3	V	33 Real Estate Tax Expense		Warren Park LLC		108,884	108,884	3
4	V	32 Interest		Warren Park LLC		146,831	146,831	4
5	V	20 Trust Fees		Warren Park LLC		150	150	5
6	V	20 Franchise Tax		Warren Park LLC		250	250	6
7	V	30 Depreciation		Warren Park LLC		69,199	69,199	7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 497,871			\$ 325,314	\$ * (172,557)	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Warren Park Nursing Pavilion# 0036079Report Period Beginning: 01/01/05Ending: 12/31/05

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	5 UTILITIES		DYNAMIC HEALTH CARE CONS.	100.00%	\$ 854	\$ 854	15
16	V	6 REPAIRS & MAINT.				2,431	2,431	16
17	V	19 PROFESSIONAL FEES	260,890			1,778	(259,112)	17
18	V	20 DUES AND SUBSCRIPTIONS				652	652	18
19	V	21 CLERICAL & GENERAL				34,595	34,595	19
20	V	24 SEMINARS AND TRAVEL				71	71	20
21	V	25 AUTO EXP.				1,137	1,137	21
22	V	26 INSURANCE				1,444	1,444	22
23	V	27 EMP.BEN. - GEN. ADMIN.				7,144	7,144	23
24	V	30 DEPRECIATION				1,911	1,911	24
25	V	32 INTEREST				2,136	2,136	25
26	V	33 REAL ESTATE TAXES				2,287	2,287	26
27	V	35 EQUIPMENT RENTAL				3,817	3,817	27
28	V							28
29	V	17 Management Fees	33,000				(33,000)	29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$ 293,890			\$ 60,257	\$ * (233,633)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Warren Park Nursing Pavilion # 0036079 Report Period Beginning: 01/01/05 Ending: 12/31/05

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	6 MAINT. CMP. - D. NEHMER	\$	DYNAMIC HEALTH CARE CONS.	100.00%	\$ 4,782	\$ 4,782	15
16	V	17 ADMIN. CMP. - M. MAUER				13,175	13,175	16
17	V	17 ADMIN. CMP. - M. AARON				14,747	14,747	17
18	V	17 ADMIN. CMP. - F. AARON						18
19	V	17 ADMIN. CMP. - S. GOLDSTEIN				18,667	18,667	19
20	V	17 ADMIN. CMP. - S. KOPLIN				8,590	8,590	20
21	V	17 ADMIN. CMP. - D. MAGAFAS				9,069	9,069	21
22	V	17 ADMIN. CMP. - S. LEVY				12,271	12,271	22
23	V	17 ADMIN. CMP. - HOWARD ALTER						23
24	V	17 ADMIN. CMP. - NON-OWNER				14,788	14,788	24
25	V	21 CLERICAL CMP. - S. AARON				5,255	5,255	25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$ 101,344	\$ * 101,344	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

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

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

1 Schedule V	2 Line	3 Cost Per General Ledger		5 Cost to Related Organization		6 Percent of Ownership	7		8 Difference: Adjustments for Related Organization Costs (7 minus 4)
		Item	4 Amount	Name of Related Organization	Operating Cost of Related Organization				
15	V	7	EMP. BEN.- D. NEHMER	\$	DYNAMIC HEALTH CARE CONS.	100.00%	\$ 465	\$ 465	15
16	V	27	EMP. BEN.- M. MAUER				901	901	16
17	V	27	EMP. BEN.- M. AARON				1,174	1,174	17
18	V	27	EMP. BEN.- F. AARON						18
19	V	27	EMP. BEN.- S. GOLDSTEIN				26,171	26,171	19
20	V	27	EMP. BEN.- S. KOPLIN				3,007	3,007	20
21	V	27	EMP. BEN.- D. MAGAFAS				734	734	21
22	V	27	EMP. BEN.- S. LEVY				1,924	1,924	22
23	V	27	EMP. BEN.- HOWARD ALTER						23
24	V	27	EMP. BEN.- NON-OWNER				2,426	2,426	24
25	V	27	EMP. BEN. - S. AARON				1,164	1,164	25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$ 37,966	\$ * 37,966	39

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V		\$			\$		15
16	V	10 MEDICAL SUPPLIES	16,283	LINCOLN MEDICAL SUPPLIES, INC.	100.00%	11,535	(4,748)	16
17	V	39 ANCILLARY EXPENSE	8,120	LINCOLN MEDICAL SUPPLIES, INC.	100.00%	5,753	(2,367)	17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$ 24,403			\$ 17,288	\$ * (7,115)	39

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

VII. RELATED PARTIES (continued)

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

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

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

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

Facility Name & ID Number Warren Park Nursing Pavilion

0036079

Report Period Beginning: 01/01/05

Ending: 12/31/05

VII. RELATED PARTIES (continued)

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

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

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

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

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

VII. RELATED PARTIES (continued)

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

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

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

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

Facility Name & ID Number Warren Park Nursing Pavilion

0036079

Report Period Beginning: 01/01/05

Ending: 12/31/05

VII. RELATED PARTIES (continued)

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Warren Park Nursing Pavilion # 0036079 Report Period Beginning: 01/01/05 Ending: 12/31/05

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	Marshall Mauer	Owner	Administrative	6.30%	See Attached	3.10	6.20%	Alloc. Dynam	\$ 13,175	17-7	1
2	Maury Aaron	Owner	Administrative	19.69%	See Attached	3.47	6.94%	Alloc. Dynam	14,747	17-7	2
3	Sharon Aaron	Relative	Clerical	0.00%	See Attached	3.10	7.75%	Alloc. Dynam	5,255	21-7	3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 33,177		13

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Warren Park Nursing Pavilion

0036079

Report Period Beginning: 01/01/05

Ending: 12/31/05

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 _____
 Street Address _____
 City / State / Zip Code _____
 Phone Number () _____
 Fax Number () _____

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Warren Park Nursing Pavilion

0036079

Report Period Beginning:

01/01/05

Ending: 12/31/05

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization DYNAMIC HEALTH CARE CONS.
 Street Address 3359 W. MAIN STREET
 City / State / Zip Code SKOKIE, IL. 60076
 Phone Number (847) 679-8219
 Fax Number (847) 679-7377

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	5	UTILITIES	PATIENT DAYS	413,836	12	\$ 11,039	\$ 32,025	\$ 854	1
2	6	REPAIRS & MAINT.	PATIENT DAYS	413,836	12	31,419	32,025	2,431	2
3	19	PROFESSIONAL FEES	PATIENT DAYS	413,836	12	22,969	32,025	1,778	3
4	20	DUES AND SUBSCRIPTIONS	PATIENT DAYS	413,836	12	8,420	32,025	652	4
5	21	CLERICAL & GENERAL	PATIENT DAYS	413,836	12	447,045	345,326	34,595	5
6	24	SEMINARS AND TRAVEL	PATIENT DAYS	413,836	12	917	32,025	71	6
7	25	AUTO EXP.	PATIENT DAYS	413,836	12	14,696	32,025	1,137	7
8	26	INSURANCE	PATIENT DAYS	413,836	12	18,661	32,025	1,444	8
9	27	EMP.BEN. - GEN. ADMIN.	PATIENT DAYS	413,836	12	92,321	32,025	7,144	9
10	30	DEPRECIATION	PATIENT DAYS	413,836	12	24,690	32,025	1,911	10
11	32	INTEREST	PATIENT DAYS	413,836	12	27,602	32,025	2,136	11
12	33	REAL ESTATE TAXES	PATIENT DAYS	413,836	12	29,555	32,025	2,287	12
13	35	EQUIPMENT RENTAL	PATIENT DAYS	413,836	12	49,319	32,025	3,817	13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 778,653	\$ 345,326	\$ 60,257	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Warren Park Nursing Pavilion

0036079

Report Period Beginning: 01/01/05

Ending: 12/31/05

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization DYNAMIC HEALTH CARE CONS.
 Street Address 3359 W. MAIN STREET
 City / State / Zip Code SKOKIE, IL. 60076
 Phone Number (847) 679-8219
 Fax Number (847) 679-7377

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	6	MAINT. CMP. - D. NEHMER	WGHTD. AVG. HOURS	40	9	55,120	55,120	3	4,782	1
2	17	ADMIN. CMP. - M. MAUER	WGHTD. AVG. HOURS	40	11	170,000	170,000	3	13,175	2
3	17	ADMIN. CMP. - M. AARON	WGHTD. AVG. HOURS	40	9	170,000	170,000	3	14,747	3
4	17	ADMIN. CMP. - F. AARON	WGHTD. AVG. HOURS	47	6	88,500	88,500			4
5	17	ADMIN. CMP. - S. GOLDSTEIN	WGHTD. AVG. HOURS	45	3	24,000	24,000	35	18,667	5
6	17	ADMIN. CMP. - S. KOPLIN	WGHTD. AVG. HOURS	40	7	72,485	72,485	5	8,590	6
7	17	ADMIN. CMP. - D. MAGAFAS	WGHTD. AVG. HOURS	45	9	104,642	104,642	4	9,069	7
8	17	ADMIN. CMP. - S. LEVY	WGHTD. AVG. HOURS	45	11	158,233	158,233	3	12,271	8
9	17	ADMIN. CMP. - HOWARD ALT	WGHTD. AVG. HOURS	40	1	12,000	12,000			9
10	17	ADMIN. CMP. - NON-OWNER	WGHTD. AVG. HOURS	45	9	170,636	170,636	4	14,788	10
11	21	CLERICAL CMP. - S. AARON	WGHTD. AVG. HOURS	40	11	67,785	67,785	3	5,255	11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 1,093,401	\$ 1,093,399		\$ 101,344	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Warren Park Nursing Pavilion

0036079 Report Period Beginning: 01/01/05

Ending: 12/31/05

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization DYNAMIC HEALTH CARE CONS.
 Street Address 3359 W. MAIN STREET
 City / State / Zip Code SKOKIE, IL. 60076
 Phone Number (847) 679-8219
 Fax Number (847) 679-7377

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	7	EMP. BEN.- D. NEHMER	WGHTD. AVG. HOURS	40	9	5,362	3	465	1
2	27	EMP. BEN.- M. MAUER	WGHTD. AVG. HOURS	40	11	11,631	3	901	2
3	27	EMP. BEN.- M. AARON	WGHTD. AVG. HOURS	40	9	13,532	3	1,174	3
4	27	EMP. BEN.- F. AARON	WGHTD. AVG. HOURS	47	6	42,295			4
5	27	EMP. BEN.- S. GOLDSTEIN	WGHTD. AVG. HOURS	45	3	33,649	35	26,171	5
6	27	EMP. BEN.- S. KOPLIN	WGHTD. AVG. HOURS	40	7	25,376	5	3,007	6
7	27	EMP. BEN.- D. MAGAFAS	WGHTD. AVG. HOURS	45	9	8,470	4	734	7
8	27	EMP. BEN.- S. LEVY	WGHTD. AVG. HOURS	45	11	24,807	3	1,924	8
9	27	EMP. BEN.- HOWARD ALTER	WGHTD. AVG. HOURS	40	1	1,105			9
10	27	EMP. BEN.- NON-OWNER	WGHTD. AVG. HOURS	45	9	27,997	4	2,426	10
11	27	EMP. BEN. - S. AARON	WGHTD. AVG. HOURS	40	11	15,016	3	1,164	11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 209,240	\$	\$ 37,966	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Warren Park Nursing Pavilion

0036079

Report Period Beginning: 01/01/05

Ending: 12/31/05

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization LINCOLN MEDICAL SUPPLIES, INC.
 Street Address 3359 W. MAIN STREET
 City / State / Zip Code SKOKIE, IL. 60076
 Phone Number (847) 679-8219
 Fax Number (847) 679-7377

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1									1
2	10	MEDICAL SUPPLIES						11,535	2
3	39	ANCILLARY EXPENSE						5,753	3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$ 17,288	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Warren Park Nursing Pavilion

0036079

Report Period Beginning: 01/01/05

Ending: 12/31/05

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Warren Park Nursing Pavilion

0036079

Report Period Beginning: 01/01/05

Ending: 12/31/05

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Warren Park Nursing Pavilion

0036079

Report Period Beginning: 01/01/05

Ending: 12/31/05

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Warren Park Nursing Pavilion

0036079

Report Period Beginning:

01/01/05

Ending: 12/31/05

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 _____
 Street Address _____
 City / State / Zip Code _____
 Phone Number () _____
 Fax Number () _____

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Warren Park Nursing Pavilion

0036079

Report Period Beginning:

01/01/05

Ending: 12/31/05

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	Name of Lender	2		3	4	5	6		8	9	10						
		Related**					Purpose of Loan	Monthly Payment Required				Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO										Original	Balance			
A. Directly Facility Related																	
Long-Term																	
1	Devon Bank		X	Mortgage		6/1/95	\$	\$ 1,360,463			\$ 146,831	1					
2	MB Financial		X	Note Payable				26,000			32,917	2					
3												3					
4												4					
5	See Supplemental Schedule											5					
Working Capital																	
6	MB Financial		X	Line Of Credit			700,000	645,000			5,094	6					
7	Insurance		X				97,527				2,809	7					
8	See Supplemental Schedule										7,727	8					
9	TOTAL Facility Related						\$ 797,527	\$ 2,031,463			\$ 195,378	9					
B. Non-Facility Related*																	
10	Interest Income		X								(17,747)	10					
11												11					
12												12					
13	See Supplemental Schedule											13					
14	TOTAL Non-Facility Related						\$	\$			\$ (17,747)	14					
15	TOTALS (line 9+line14)						\$ 797,527	\$ 2,031,463			\$ 177,631	15					

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Warren Park Nursing Pavilion # 0036079 Report Period Beginning: 01/01/05 Ending: 12/31/05

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

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

1	2	3	4	5	6	7	8	9	10											
										Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
											YES	NO				Original	Balance			
A. Directly Facility Related																				
Long-Term																				
1										1										
2										2										
3										3										
4										4										
5										5										
6										6										
7	TOTAL Long-Term									7										
Working Capital																				
8	MB Financial Bank		X	Working Capital						5,591										
9	Allocate From Dynamic		X							2,136										
10										10										
11										11										
12										12										
13										13										
14	TOTAL Working Capital									7,727										
B. Non-Facility Related*																				
15										15										
16										16										
17										17										
18										18										
19										19										
20	TOTAL Non-Facility Related									20										

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

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

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 Warren Park Nursing Pavilion COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0036079

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE (847)236-1111 FAX #: (847)236-1155

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>11-31-302-008-0000</u>	<u>Long Term Care Property</u>	\$ <u>46,476.90</u>	\$ <u>46,476.90</u>
2. <u>11-31-302-043-0000</u>	<u>Long Term Care Property</u>	\$ <u>70,616.46</u>	\$ <u>70,616.46</u>
3. <u>10-23-404-059-0000</u>	<u>Home Office</u>	\$ <u>29,908.15</u>	\$ <u>2,314.46</u>
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>147,001.51</u>	\$ <u>119,407.82</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? X YES NO

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

C. Tax Bills

Attach a copy of the 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.

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 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 Warren Park Nursing Pavilion COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0036079

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE (847)236-1111 FAX #: (847)236-1155

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. _____	_____	\$ _____	\$ _____
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ _____	\$ _____

B. Real Estate Tax Cost Allocations

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

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

C. Tax Bills

Attach a copy of the 2004 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2005.

Facility Name & ID Number Warren Park Nursing Pavilion

0036079 Report Period Beginning:

01/01/05 Ending:

12/31/05

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 43,400 B. General Construction Type: Exterior Brick Frame _____ Number of Stories 3

C. Does the Operating Entity? (a) Own the Facility (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.

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

D. Does the Operating Entity? (a) Own the Equipment (b) Rent equipment from a Related Organization. (c) Rent equipment from Completely Unrelated Organization.

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

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

None

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

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

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

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>Facility</u>		<u>1985</u>	<u>\$ 158,750</u>	1
2					2
3	TOTALS			\$ 158,750	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Warren Park Nursing Pavilion

0036079

Report Period Beginning:

01/01/05

Ending:

12/31/05

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			1990	177,699		20	8,885	8,885	138,225	9
10	Various			1991	40,276		20	2,014	2,014	29,154	10
11	Various			1992	26,271		20	1,314	1,314	18,068	11
12	Various			1993	39,480		20	1,969	1,969	24,065	12
13	Various			1994	61,455		20	3,074	3,074	34,766	13
14	Various			1995	53,672		20	2,685	2,685	28,574	14
15	Various			1996	5,720		20	286	286	2,776	15
16	Various			1997	31,153		20	1,558	1,558	13,481	16
17	Various			1998	142,888		20	7,149	7,149	53,133	17
18	Various			1999	22,019		20	1,103	1,103	7,111	18
19	Various			2000	160,109		20	7,883	7,883	43,645	19
20	Various			2001	44,572		20	3,728	3,728	15,889	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

*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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Warren Park Nursing Pavilion

0036079

Report Period Beginning:

01/01/05

Ending:

12/31/05

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		2,698,750	69,199		134,938	65,739	1,428,094	67
68		34,328	880		981	101	12,096	68
69			34,050			(34,050)		69
70		\$ 3,538,392	\$ 104,129		\$ 177,567	\$ 73,438	\$ 1,849,077	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Warren Park Nursing Pavilion

0036079

Report Period Beginning:

01/01/05

Ending:

12/31/05

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 3,538,392	\$ 104,129		\$ 177,567	\$ 73,438	\$ 1,849,077	1
2	Telephone System	2002	10,122		20	1,012	1,012	3,205	2
3	Sewer Pipe	2002	3,100		20	310	310	1,240	3
4	Chimney Reconstruct	2002	1,350		20	135	135	439	4
5	Electrical Outlet Installation	2002	1,800		20	180	180	555	5
6	Removal Of Trees	2002	1,800		20	180	180	630	6
7	Glass Installation	2002	1,161		20	116	116	455	7
8	Install Emergency Light	2002	1,149		20	115	115	393	8
9	Patient Monitoring System	2003	14,634		20	1,463	1,463	3,780	9
10	Pagers And Watcher For Monitoring System	2003	830		20	83	83	249	10
11	Circuit For New Electric Stove	2003	850		20	85	85	227	11
12	Dedicated Circuit For Copier	2003	650		20	65	65	173	12
13	Security Cameras And Monitors	2003	2,355		20	236	236	569	13
14	Centrifical Roof Exhauster	2003	515		20	51	51	124	14
15	2 Centrifical Roof Exhausters	2003	1,054		20	105	105	255	15
16	Door Alarm	2003	695		20	70	70	156	16
17	Cameras, Etc	2003	1,175		20	118	118	255	17
18	Repair Cooler	2003	521		20	26	26	72	18
19	Building Material	2003	958		20	48	48	136	19
20	Sprinkler Heads, Splash Guards	2003	975		20	49	49	134	20
21	Rotary, Hinge Prep, Lite Kit, Glass	2003	1,241		20	62	62	171	21
22	Thermostat, Clean Cond. Unit	2003	545		20	27	27	70	22
23	Pump, Motor, Fan Blade	2003	786		20	39	39	102	23
24	Emergency Lights, Battery	2003	1,389		20	69	69	168	24
25	Water Heater	2004	5,765		20	577	577	913	25
26	Handicapp Ramp In Entrance	2004	6,626		20	663	663	994	26
27	Pine Roofing - Roof Repairs	2004	2,405		20	241	241	261	27
28	Install Sprinkler Heads	2004	1,176		20	118	118	147	28
29	Elevator Repairs	2005	2,959		20	296	296	296	29
30	Repair Kitchen Exhaust Motor And Starter	2005	2,300		20	58	58	58	30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,609,278	\$ 104,129		\$ 184,164	\$ 80,035	\$ 1,865,304	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
1	Totals from Page 12B, Carried Forward	\$ 3,609,278	\$ 104,129		\$ 184,164	\$ 80,035	\$ 1,865,304		1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)	\$ 3,609,278	\$ 104,129		\$ 184,164	\$ 80,035	\$ 1,865,304		34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
1	Totals from Page 12C, Carried Forward	\$ 3,609,278	\$ 104,129		\$ 184,164	\$ 80,035	\$ 1,865,304		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
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28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)	\$ 3,609,278	\$ 104,129		\$ 184,164	\$ 80,035	\$ 1,865,304		34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
1	Totals from Page 12D, Carried Forward	\$ 3,609,278	\$ 104,129		\$ 184,164	\$ 80,035	\$ 1,865,304		1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)	\$ 3,609,278	\$ 104,129		\$ 184,164	\$ 80,035	\$ 1,865,304		34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
1	Totals from Page 12E, Carried Forward	\$ 3,609,278	\$ 104,129		\$ 184,164	\$ 80,035	\$ 1,865,304		1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)	\$ 3,609,278	\$ 104,129		\$ 184,164	\$ 80,035	\$ 1,865,304		34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
1	Totals from Page 12F, Carried Forward	\$ 3,609,278	\$ 104,129		\$ 184,164	\$ 80,035	\$ 1,865,304		1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)	\$ 3,609,278	\$ 104,129		\$ 184,164	\$ 80,035	\$ 1,865,304		34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
1	Totals from Page 12G, Carried Forward	\$ 3,609,278	\$ 104,129		\$ 184,164	\$ 80,035	\$ 1,865,304		1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)	\$ 3,609,278	\$ 104,129		\$ 184,164	\$ 80,035	\$ 1,865,304		34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

B. Building 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	
1		\$ 3,609,278	\$ 104,129		\$ 184,164	\$ 80,035	\$ 1,865,304	1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34	TOTAL (lines 1 thru 33)	\$ 3,609,278	\$ 104,129		\$ 184,164	\$ 80,035	\$ 1,865,304	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

B. Building 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	
1		\$ 3,609,278	\$ 104,129		\$ 184,164	\$ 80,035	\$ 1,865,304	1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34	TOTAL (lines 1 thru 33)	\$ 3,609,278	\$ 104,129		\$ 184,164	\$ 80,035	\$ 1,865,304	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

B. Building 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	
1		\$ 3,609,278	\$ 104,129		\$ 184,164	\$ 80,035	\$ 1,865,304	1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34	TOTAL (lines 1 thru 33)	\$ 3,609,278	\$ 104,129		\$ 184,164	\$ 80,035	\$ 1,865,304	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Warren Park Nursing Pavilion

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	127		1995	1969	\$ 2,698,750	\$ 69,199	39	\$ 134,938	\$ 65,739	\$ 1,428,094	4
5											5
6											6
7											7
8											8
Improvement Type**											
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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Warren Park Nursing Pavilion

0036079

Report Period Beginning:

01/01/05

Ending:

12/31/05

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)	\$	\$		\$	\$	\$	70
			2,698,750		69,199		134,938	
						65,739	1,428,094	

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Warren Park Nursing Pavilion

0036079

Report Period Beginning:

01/01/05

Ending:

12/31/05

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	Allocate From Dynamic		1993	1993	\$ 34,328	\$ 880	39	\$ 981	\$ 101	\$ 12,096	4
5											5
6											6
7											7
8											8
	Improvement Type**										
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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Warren Park Nursing Pavilion

0036079

Report Period Beginning:

01/01/05

Ending:

12/31/05

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)	\$	\$		\$	\$	\$	70
			34,328	880	981	101	12,096	

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Warren Park Nursing Pavilion # 0036079 Report Period Beginning: 01/01/05 Ending: 12/31/05

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	\$ 147,820	\$ 170	\$ 16,166	\$ 15,996	10	\$ 95,967	71
72	Current Year Purchases	9,820		997	997	10	997	72
73	Fully Depreciated Assets	444,449				10	444,449	73
74								74
75	TOTALS	\$ 602,089	\$ 170	\$ 17,163	\$ 16,993		\$ 541,413	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		DODGE - MIDWAY	1993	\$ 21,583	\$	\$	\$	5	\$ 21,583	76
77		1999 Lexus RX300	2003	16,000		2,856	2,856	5	9,336	77
78		ALLOCATE FROM DYNAMIC	2003	13,344	860	899	39	5	5,255	78
79										79
80	TOTALS			\$ 50,927	\$ 860	\$ 3,755	\$ 2,895		\$ 36,174	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)	\$ 4,421,044	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 105,159	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 205,082	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 99,923	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 2,442,891	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.

SEE ACCOUNTANTS' COMPILATION REPORT

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

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

If NO, see instructions.

YES NO

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

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	\$ _____

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: \$ 9,343 Description: See Attached Schedule

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

* 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>
--	---	--

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.
- SEE ACCOUNTANTS' COMPILATION REPORT

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 - 03	hrs	\$		\$ 37,962	\$		\$ 37,962	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			1,248			1,248	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			38,716			38,716	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 02	# of prescripts				23,341		23,341	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): See Supplemental						18,010		18,010	13
14	TOTAL			\$		\$ 77,926	\$ 41,351		\$ 119,277	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Warren Park Nursing Pavilion# 0036079Report Period Beginning: 01/01/05

Ending:

12/31/05**XV. BALANCE SHEET - Unrestricted Operating Fund.**As of 12/31/05

(last day of reporting year)

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

		1 Operating	2 After Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$ 527	\$ 55,297	1
2	Cash-Patient Deposits	68,880	68,880	2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	825,332	835,332	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	54,878	54,878	6
7	Other Prepaid Expenses	4,140	4,140	7
8	Accounts Receivable (owners or related parties)	319,951	362,024	8
9	Other(specify): <u>See Attached Schedule</u>	45,000	88,914	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,318,708	\$ 1,469,465	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		158,750	13
14	Buildings, at Historical Cost		2,698,750	14
15	Leasehold Improvements, at Historical Cost	808,243	1,125,743	15
16	Equipment, at Historical Cost	300,981	300,981	16
17	Accumulated Depreciation (book methods)	(501,394)	(1,548,366)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	7,000	7,000	19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(7,000)	(7,000)	20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <u>See Attached Schedule</u>	216,439	95	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 824,269	\$ 2,735,953	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,142,977	\$ 4,205,418	25

		1 Operating	2 After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 251,573	\$ 251,574	26
27	Officer's Accounts Payable	479,200	479,200	27
28	Accounts Payable-Patient Deposits	68,880	68,880	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	93,288	93,288	30
31	Accrued Taxes Payable (excluding real estate taxes)	6,476	6,476	31
32	Accrued Real Estate Taxes(Sch.IX-B)	120,000	120,000	32
33	Accrued Interest Payable	825	132,162	33
34	Deferred Compensation			34
35	Federal and State Income Taxes	4,292	4,292	35
Other Current Liabilities(specify):				
36	<u>See Attached Schedule</u>	9,923	9,923	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,034,457	\$ 1,165,795	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable	671,000	2,031,463	39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
Other Long-Term Liabilities(specify):				
43	<u>See Attached Schedule</u>			43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 671,000	\$ 2,031,463	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,705,457	\$ 3,197,258	46
47	TOTAL EQUITY (page 18, line 24)	\$ 437,520	\$ 1,008,160	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,142,977	\$ 4,205,418	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 408,940	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 408,940	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	28,580	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)	\$ 28,580	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)	\$ 437,520	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Warren Park Nursing Pavilion# 0036079Report Period Beginning: 01/01/05Ending: 12/31/05**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	\$ 3,765,087	1
2	Discounts and Allowances for all Levels	(291,427)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,473,660	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	287,200	6
7	Oxygen	839	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 288,039	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	35,735	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	2,026	19
20	Radiology and X-Ray	182	20
21	Other Medical Services	27,178	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 65,121	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	17,747	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 17,747	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>See Supplemental Schedule</u>	11,311	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 11,311	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 3,855,878	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	764,176	31
32	Health Care	1,174,865	32
33	General Administration	1,102,545	33
B. Capital Expense			
34	Ownership	582,751	34
C. Ancillary Expense			
35	Special Cost Centers	133,428	35
36	Provider Participation Fee	69,533	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 3,827,298	40
41	Income before Income Taxes (line 30 minus line 40)**	28,580	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 28,580	43

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? Cash Basis If not, please attach a reconciliation.

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

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

Facility Name & ID Number Warren Park Nursing Pavilion

0036079

Report Period Beginning:

01/01/05

Ending:

12/31/05

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	161	163	\$ 27,216	\$ 166.97	1
2	Assistant Director of Nursing	680	680	18,205	26.77	2
3	Registered Nurses	6,498	7,180	119,362	16.62	3
4	Licensed Practical Nurses	10,931	11,139	315,022	28.28	4
5	CNAs & Orderlies	40,561	43,303	391,258	9.04	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	17	17	694	40.82	8
9	Activity Director	1,900	2,030	31,558	15.55	9
10	Activity Assistants	3,709	3,872	31,837	8.22	10
11	Social Service Workers	5,224	5,848	90,662	15.50	11
12	Dietician					12
13	Food Service Supervisor	1,828	2,118	33,732	15.93	13
14	Head Cook	8,951	9,730	98,947	10.17	14
15	Cook Helpers/Assistants	8,375	9,236	75,925	8.22	15
16	Dishwashers					16
17	Maintenance Workers	1,916	2,246	32,481	14.46	17
18	Housekeepers	10,876	11,764	103,592	8.81	18
19	Laundry	4,975	5,417	43,881	8.10	19
20	Administrator	2,044	2,086	63,136	30.27	20
21	Assistant Administrator					21
22	Other Administrative			3,500		22
23	Office Manager					23
24	Clerical	5,096	5,302	51,978	9.80	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	1,983	2,023	15,526	7.67	31
32	Other Health Care(specify)					32
33	Other(specify) <u>See Supplemental</u>	608	616	14,151	22.97	33
34	TOTAL (lines 1 - 33)	116,333	124,770	\$ 1,562,663 *	\$ 12.52	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	213	\$ 6,720	01-03	35
36	Medical Director	84	4,200	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant	63	2,496	10-03	38
39	Pharmacist Consultant	142	5,658	10-03	39
40	Physical Therapy Consultant	3	152	10a-03	40
41	Occupational Therapy Consultant	3	141	10a-03	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	1	51	10a-03	43
44	Activity Consultant	46	2,161	11-03	44
45	Social Service Consultant	45	2,493	12-03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	600	\$ 24,072		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	56	\$ 4,571	10-03	50
51	Licensed Practical Nurses	1,385	49,184	10-03	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	1,441	\$ 53,755		53

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Warren Park Nursing Pavilion

0036079

Report Period Beginning: 01/01/05

Ending: 12/31/05

XIX. SUPPORT SCHEDULES

A. Administrative Salaries			D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions		
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
Steven Goldstein	Administrator	0	\$ 63,136	Workers' Compensation Insurance	\$ 36,568	IDPH License Fee	\$	
Howard Alter	Administrator	0	3,500	Unemployment Compensation Insurance	41,988	Advertising: Employee Recruitment	485	
				FICA Taxes	118,757	Health Care Worker Background Check		
				Employee Health Insurance		(Indicate # of checks performed)		
				Employee Meals	40,022	Licenses And Permits	4,256	
				Illinois Municipal Retirement Fund (IMRF)*	47,668	IL Council on LTC	5,597	
				Chicago Head Tax	3,738	Allocate From Dynamic	652	
				Other Employee Benefits	10,212			
TOTAL (agree to Schedule V, line 17, col. 1)			\$ 66,636	TOTAL (agree to Schedule V, line 22, col.8)		\$ 10,990		
B. Administrative - Other						Less: Public Relations Expense ()		
Description			Amount			Non-allowable advertising ()		
Management Fees - Dynamic			\$ 33,000			Yellow page advertising ()		
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 33,000			TOTAL (agree to Sch. V, line 20, col. 8)		
(Attach a copy of any management service agreement)				E. Schedule of Non-Cash Compensation Paid to Owners or Employees		G. Schedule of Travel and Seminar**		
Vendor/Payee	Type	Amount	Description	Line #	Amount	Description	Amount	
FR&R	Accounting	\$ 10,045			\$	Out-of-State Travel	\$	
Dynamic Healthcare	Bookkeeping	260,400						
Health Data Systems	Data Processing	3,349						
Econocare	Purchasing Consultants	3,786				In-State Travel		
Personnel Planners	Unemployment Consult	2,550						
Dynamic Healthcare	Accounting	490						
Robinson & Associates	Computer Service	90				Seminar Expense	1,871	
Marketing	Adj On 5A	32,306				Allocate From Dynamic	71	
See Attached	Legal Fees	52,048						
TOTAL (agree to Schedule V, line 19, column 3)			\$ 365,064	TOTAL		Entertainment Expense ()		
(If total legal fees exceed \$2500 attach copy of invoices.)						(agree to Sch. V, line 24, col. 8)		
						TOTAL \$ 1,942		

* Attach copy of IMRF notifications
SEE ACCOUNTANTS' COMPILATION REPORT

**See instructions.

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

	1 Improvement Type	2 Month & Year Improvement Was Made	3 Total Cost	4 Useful Life	Amount of Expense Amortized Per Year								
					5 FY2002	6 FY2003	7 FY2004	8 FY2005	9 FY2006	10 FY2007	11 FY2008	12 FY2009	13 FY2010
1	N/A		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
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14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Warren Park Nursing Pavilion

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 Council - \$1,870.90
- (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? N/A
- (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 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 962 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 69,533
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? N/A
- (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. \$ 40,022 Has any meal income been offset against related costs? No Indicate the amount. \$ N/A
- (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. \$ N/A
- c. What percent of all travel expense relates to transportation of nurses and patients? 100% ln14
- d. Have vehicle usage logs been maintained? Yes
- e. Are all vehicles stored at the nursing home during the night and all other times when not in use? No
- f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
- 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: N/A The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? N/A If no, please explain. N/A
- (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.

SEE ACCOUNTANTS' COMPILATION REPORT