

Facility Name & ID Number OAK PARK HEALTHCARE CENTER

0044602 Report Period Beginning: 01/01/2006 Ending: 12/31/2006

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	204	Skilled (SNF)	204	74,460	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	204	TOTALS	204	74,460	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	963		3,641	4,604	8
9	SNF/PED					9
10	ICF	32,905	936		33,841	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	33,868	936	3,641	38,445	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 51.63%

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

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

NONE

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

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

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

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

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

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 32 and days of care provided 3,641

Medicare Intermediary ADMINASTAR

IV. ACCOUNTING BASIS

ACCRAUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/2006 Fiscal Year: 12/31/2006

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

Facility Name & ID Number **OAK PARK HEALTHCARE CENTER** # **0044602** Report Period Beginning: **01/01/2006** Ending: **12/31/2006**

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	183,948	21,975	11,886	217,809		217,809	0	217,809		1
2	Food Purchase		164,848		164,848	(14,235)	150,613	(399)	150,214		2
3	Housekeeping	154,451	25,200	0	179,651		179,651	0	179,651		3
4	Laundry	63,480	11,980	0	75,460	0	75,460	0	75,460		4
5	Heat and Other Utilities			154,222	154,222		154,222	28	154,250		5
6	Maintenance	43,398	27,813	42,412	113,623		113,623	4,652	118,275		6
7	Other (specify):*			14,712	14,712		14,712	13	14,725		7
8	TOTAL General Services	445,277	251,816	223,232	920,325	(14,235)	906,090	4,294	910,384		8
	B. Health Care and Programs										
9	Medical Director	0		4,500	4,500		4,500	0	4,500		9
10	Nursing and Medical Records	1,711,995	71,566	4,408	1,787,969		1,787,969	34,335	1,822,304		10
10a	Therapy	75,467	7,796	131,103	214,366		214,366	(13,514)	200,852		10a
11	Activities	70,491	8,969	888	80,348		80,348	0	80,348		11
12	Social Services	89,106		28	89,134		89,134	0	89,134		12
13	CNA Training			0	0		0	0	0		13
14	Program Transportation			350	350		350	0	350		14
15	Other (specify):*				0		0	0	0		15
16	TOTAL Health Care and Programs	1,947,059	88,331	141,277	2,176,667	0	2,176,667	20,821	2,197,488		16
	C. General Administration										
17	Administrative	114,210		0	114,210		114,210	77,480	191,690		17
18	Directors Fees			0	0		0	0	0		18
19	Professional Services			270,331	270,331		270,331	(210,073)	60,258		19
20	Dues, Fees, Subscriptions & Promotions			63,081	63,081		63,081	(6,866)	56,215		20
21	Clerical & General Office Expenses	62,024	17,074	215,287	294,385		294,385	(141,434)	152,951		21
22	Employee Benefits & Payroll Taxes			482,409	482,409	14,235	496,644	0	496,644		22
23	Inservice Training & Education			384	384		384	1,535	1,919		23
24	Travel and Seminar			0	0		0	821	821		24
25	Other Admin. Staff Transportation			13,742	13,742		13,742	2,262	16,004		25
26	Insurance-Prop.Liab.Malpractice			112,651	112,651		112,651	1,095	113,746		26
27	Other (specify):*			0	0		0	42,369	42,369		27
28	TOTAL General Administration	176,234	17,074	1,157,885	1,351,193	14,235	1,365,428	(232,811)	1,132,617		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,568,570	357,221	1,522,394	4,448,185	0	4,448,185	(207,696)	4,240,489		29

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

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

V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE	SCHED REF	TOTAL
1	DIETARY	
	DIETITIAN CONSULTANT XVIII B 35-2	11,007
	REPAIRS & MAINTENANCE	747
	COSTS REBILLED - SALARIES	132
		11,886
3	HOUSEKEEPING	
		0
		0
		0
4	LAUNDRY	
	EQUIPMENT REPAIRS & MAINTENANCE	0
		0
		0
5	HEAT & OTHER UTILITIES	
	GAS HEAT	64,950
	ELECTRICITY	49,752
	WATER	39,520
	CABLE TV - LOBBY	0
		0
		154,222
6	MAINTENANCE	
	GROUNDS MAINTENANCE	3,655
	PAINTING & DECORATING	0
	BUILDING REPAIRS	0
	MAINTENANCE TRAVEL	0
	EQUIPMENT MAINTENANCE & REPAIR	21,176
	ELEVATOR MAINTENANCE & REPAIR	8,456
	OUTSIDE LABOR	0
	EXTERMINATING SERVICE	3,575
	FIRE SERVICE	5,050
	COSTS REBILLED - SALARIES	500
		0
		0
		0
		42,412
7	OTHER	
	SCAVENGER	14,631
	SECURITY SERVICE	81
		0
		0
		14,712
9	MEDICAL DIRECTOR	
	MEDICAL DIRECTOR FEES XVIII B 36-2	4,500
		4,500

LINE	SCHED REF	TOTAL
10	NURSING	
	CONTRACT NURSING XVIII C 53-2	
	LABORATORY & XRAY EXPENSE	0
	PURCHASED SERVICES	0
	PSYCHO-SOCIAL CONSULTANT XVIII B ___-2	0
	RESTORATIVE NURSING CONSULTANT XVIII B 38-2	0
	MEDICAL RECORDS CONSULTANT XVIII B 37-2	1,440
	PHARMACY CONSULTANT XVIII B 39-2	1,800
	UTILIZATION REVIEW FEES XVIII B ___-2	0
	PHYSICIANS XVIII B ___-2	0
	PSYCHIATRIC XVIII B 47-2	0
	RN CONSULTANT XVIII B 38-2	0
	COSTS REBILLED - SALARIES	1,168
	MEDICARE & PUBLIC AID CONSULTAN XVIII B 48-2	
		4,408
10a	THERAPY	
	PHYSICAL THERAPY SERVICES	10,233
	SPEECH THERAPY SERVICES	8,708
	OCCUPATIONAL THERAPY SERVICES	8,352
	REHABILITATION CONSULTANT XVIII B ___-2	0
	PHYSICAL THERAPY CONSULTANT XVIII B 40-2	7,200
	OCCUPATIONAL THERAPY CONSULTA XVIII B 41-2	7,200
	RESPIRATORY THERAPY CONSULTAN XVIII B 42-2	0
	SPEECH THERAPY CONSULTANT XVIII B 43-2	0
	THERAPY CONTRACT SERVICES	89,410
		131,103
11	ACTIVITIES	
	CABLE TV - PATIENT ROOMS	0
	ACTIVITY REHAB CONSULTANT XVIII B 44-2	888
		0
		888
12	SOCIAL SERVICES	
	SOCIAL REHABILITATION SERVICES	0
	SOCIAL REHABILITATION CONSULTAN XVIII B 45-2	0
	SOCIAL WORKER XVIII B 45-2	28
		0
		28
13	NURSE AIDE TRAINING	
	NURSE AIDE TRAINING COSTS XIII	0
		0

V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE	SCHED REF	TOTAL
14	PROGRAM TRANSPORTATION	
	PATIENT TRANSPORTATION	350
17	ADMINISTRATIVE	
	MANAGEMENT FEES XIX B	0
	DIRECTORS FEES	
18	DIRECTORS FEES	0
19	PROFESSIONAL SERVICES	
	DATA PROCESSING XIX C	30,670
	ADMINISTRATIVE CONSULTANTS XIX C	198,000
	PROFESSIONAL FEES XIX C	41,661
		0
		270,331
20	FEES,SUBSCRIPTIONS,PROMOTIONS	
	ENTERTAINMENT & MARKETING VI 19 XIX F	0
	ADV & PROMO-NON PATIENT RELATED VI 25 XIX F	4,903
	EMPLOYEE WANT ADS XIX F	49,653
	CONTRIBUTIONS VI 20 XIX F	0
	DUES & SUBSCRIPTIONS XIX F	2,323
	LICENSES & PERMITS XIX F	2,114
	PUBLIC RELATIONS-PATIENT RELATED XIX F	0
	ADVERTISING-YELLOW PAGES VI 28 XIX F	2,608
	TRUST FEES / FRANCHISE TAX / ETC VI 17 XIX F	930
	CONTRIBUTIONS - POLITICAL VI 20 XIX F	300
	HEALTH CARE WORKER BACKGROUND CHEC XIX F	250
	PATIENT BACKGROUND CHECKS XIX F	0
		0
		63,081
21	CLERICAL & GENERAL OFFICE EXPENSES	
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)	0
	EQUIPMENT REPAIR & MAINTENANCE	7,749
	OUTSIDE CLERICAL SERVICES	122,400
	PENALTIES / OVERDRAFT CHARGES VI 18	52,127
	HOME OFFICE EXPENSE	0
	THEFT & DAMAGE LOSS	350
	TELEPHONE	22,342
	MESSENGER SERVICE	6,334
	COSTS REBILLED - SALARIES	3,985
		215,287

LINE	SCHED REF	TOTAL
22	EMPLOYEE BENEFITS & PAYROLL TAXES	
	FICA TAXES XIX D	195,327
	UNEMPLOYMENT COMPENSATION XIX D	109,052
	WORKERS COMPENSATION INSURANC XIX D	89,243
	HOSPITALIZATION INSURANCE XIX D	59,911
	EMPLOYEE BENEFITS - OTHER XIX D	0
	EMPLOYEE PHYSICAL EXAMS XIX D	545
	INSURANCE - EXECUTIVE LIFE VI 21/XIX D	0
	PENSION/PROFIT SHARING PLANS XIX D	28,331
	CHICAGO HEAD TAX XIX D	0
		0
		482,409
23	INSERVICE TRAINING & EDUCATION	
	EDUCATION & SEMINARS	384
		384
24	TRAVEL & SEMINARS	
	EDUCATION & SEMINARS XIX G	0
	TRAVEL XIX G	0
		0
25	ADMIN. STAFF TRANSPORTATION	
	TRANSPORTATION - STAFF	13,742
		13,742
26	INSURANCE - PROP. LIAB & MALPRACTICE	
	GENERAL INSURANCE	99,355
	GENERAL INSURANCE EXPENSE	13,296
		112,651
27	OTHER	
	BAD DEBTS VI 24	0
		0

GRAND TOTAL COLUMN 3 OTHER

1,522,394

**OAK PARK HEALTHCARE CENTER
SCHEDULES
12/31/2006**

**EMPLOYEE MEAL RECLASSIFICATION
PAGE 3 SCHEDULE V COLUMN 5 LINES 2 AND 22**

TOTAL FOOD PURCHASE	164,848
LESS SALES TAX	(399)

NET FOOD	164,449
TOTAL PATIENT CENSUS	38,445
TIME 3 MEALS PER DAY	3

TOTAL PATIENT MEALS	115,335
ADD # EMPLOYEE MEALS/DAY	30
TIME # DAYS	365

TOTAL EMPLOYEE MEALS	10,950
PATIENT MEALS	115,335
ADD EMPLOYEE MEALS	10,950

TOTAL MEALS/YEAR	126,285
NET FOOD	164,449
DIVIDE TOTAL MEALS/YEAR	126,285
COST PER MEAL	1.30
TIME EMPLOYEE MEALS	10,950

EMPLOYEE MEAL RECLASSIFICATION	14,235
=====	

**PROFESSIONAL FEES
PAGE 21 SCHEDULE XIX PART C**

CAREPLUS MGT	DATA PROCESSING	14,400
ACHIEVE HEALTHCARE	DATA PROCESSING	3,659
AMERICAN DATA	DATA PROCESSING	3,488
NATIONAL DATA CARE	DATA PROCESSING	2,005
e-HEALTH DATA SOLUTIONS	DATA PROCESSING	3,970
OMNICARE	DATA PROCESSING	3,120
ADAPTASOFT	DATA PROCESSING	27
CAREPLUS MGT	ADMINISTRATIVE CONSULTAN	198,000
KRUPNICK, BOKOR, KAGDA, LTD	ACCOUNTING	23,200
ABRAHAM A GUTNICKI ESQ	LEGAL	183
MEYER MAGENCE	LEGAL	5,083
(PRIOR YEAR MAGENCE 250 ADJUSTED OUT ON PAGE 5A LINE 2)		
IL ASSOC HEALTHCARE	LEGAL	1,530
FIRST REAL ESTATE SERVICES	APPRAISAL	3,500
CORP. SERVICE CO	PURCHASING CONSULTANT	309
PERSONNEL PLANNER	UC CONSULTANT	3,056
RICHARD PEELO	MEDICARE CONSULTANT	4,800

TOTAL PROFESSIONAL FEES		270,330
		=====

**EQUIPMENT RENTAL EXPENSE
PAGE 14 SCHEDULE XII PART B LINES 15**

CAREPLUS REHAB	RELATED PARTY EQUIP RENT	22,400
RCS MGMT	NURSING EQUIPMENT	906
JOHNSON WATER CONDITION	PLANT EQUIPMENT	360
HINCKLEY SPRINGS	WATER	93
AIR-SAVER	SMOKEETERS	2,152
FAMILY PRIDE	WASHER/DRYER	9,163
GE CAPITAL	COPIER	4,757
TOSHIBA AMERICA	COPIER	6915
NEOPOST	OFFICE EQUIPMENT	807

TOTAL EQUIPMENT RENTAL EXPENSE		47,553
		=====

**TRANSPORTATION - STAFF
PAGE 3 SCHEDULE V COLUMN 3 LINE 25**

	FLEET FUELING	CAR ALLOW	D.SHIRES P/C	K.MEALS P/C	G.DORAN P/C	TOTAL

JAN			450			
FEB			450			
MAR			450			
APR			450			
MAY			480			
JUN			450			
JUL						
AUG				221		
SEP						
OCT						
NOV				97		
DEC	8,150	2,535			9	

TOTAL	8,150	2,535	2,730	318	9	13,742
	=====	=====	=====	=====	=====	=====
	GASOLINE FOR FACILITY BANKING, MAINTENANCE, MARKETING, AND ACTIVITIES					

**EDUCATION & SEMINARS
PAGE 3 SCHEDULE V COLUMN 3 LINE 23**

DATE	SPONSOR OF SEMINAR	PURPOSE OF SEMINAR	PERSONNEL ATTENDING	LOC	COST OF SEMINAR

08/06	ELDER CARE COMMUNICATION	INFECTION CONTROL - 2006	BOOK	IL	192
09/06	ELDER CARE COMMUNICATION	INFECTION CONTROL - 2006	BOOK	IL	192

			TOTAL EDUCATION & SEMINARS		384
					=====

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY	
		Salary/Wage	Supplies	Other	Total					9	10
	D. Ownership	1	2	3	4	5	6	7	8		
30	Depreciation			94,615	94,615		94,615	(27,668)	66,947		30
31	Amortization of Pre-Op. & Org.			0	0		0	0	0		31
32	Interest			621,408	621,408		621,408	27,031	648,439		32
33	Real Estate Taxes			430,552	430,552		430,552	3,462	434,014		33
34	Rent-Facility & Grounds			692,879	692,879		692,879	0	692,879		34
35	Rent-Equipment & Vehicles			56,733	56,733		56,733	(15,977)	40,756		35
36	Other (specify):*				0		0	0	0		36
37	TOTAL Ownership			1,896,187	1,896,187	0	1,896,187	(13,152)	1,883,035		37
	Ancillary Expense										
	E. Special Cost Centers										
38	Medically Necessary Transportation				0		0	0	0		38
39	Ancillary Service Centers		144,504	216,627	361,131		361,131	(26,165)	334,966		39
40	Barber and Beauty Shops				0		0	0	0		40
41	Coffee and Gift Shops				0		0	0	0		41
42	Provider Participation Fee			111,690	111,690		111,690	0	111,690		42
43	Other (specify):*				0		0	0	0		43
44	TOTAL Special Cost Centers	0	144,504	328,317	472,821	0	472,821	(26,165)	446,656		44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,568,570	501,725	3,746,898	6,817,193	0	6,817,193	(247,013)	6,570,180		45

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

VI. ADJUSTMENT DETAIL

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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(39,243)	30		9
10	Interest and Other Investment Income	(3)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(399)	2		13
14	Non-Care Related Interest	(4)	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees	(930)	20		17
18	Fines and Penalties	(52,127)	21		18
19	Entertainment				19
20	Contributions	(300)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(4,903)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(2,608)	20		28
29	Other-Attach Schedule	(20,207)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (120,724)		\$ 0	30

BHF USE ONLY					
48	49	50	51	52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(126,289)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (126,289)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (247,013)		37

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

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

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

OAK PARK HEALTHCARE CENTER

ID# 0044602

Report Period Beginning: 01/01/2006

Ending: 12/31/2006

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1		\$		1
2	MARKETING SALARY	(19,957)	21	2
3	PRIOR PERIOD LEGAL-MAGENCE	(250)	19	3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(20,207)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number OAK PARK HEALTHCARE CENTER# 0044602 Report Period Beginning:

01/01/2006

Ending: 12/31/2006

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(399)	0	0	0	0	0	0	0	0	0	0	(399)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	28	0	0	0	0	0	0	0	0	0	28	5
6	Maintenance	0	4,652	0	0	0	0	0	0	0	0	0	4,652	6
7	Other (specify):*	0	13	0	0	0	0	0	0	0	0	0	13	7
8	TOTAL General Services	(399)	4,693	0	0	0	0	0	0	0	0	0	4,294	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	34,335	0	0	0	0	0	0	0	0	0	34,335	10
10a	Therapy	0	2,321	(15,835)	0	0	0	0	0	0	0	0	(13,514)	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	36,656	(15,835)	0	20,821	16							
	C. General Administration													
17	Administrative	0	0	77,480	0	0	0	0	0	0	0	0	77,480	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(250)	(212,400)	2,577	0	0	0	0	0	0	0	0	(210,073)	19
20	Fees, Subscriptions & Promotions	(8,741)	0	1,875	0	0	0	0	0	0	0	0	(6,866)	20
21	Clerical & General Office Expenses	(72,084)	(122,400)	53,050	0	0	0	0	0	0	0	0	(141,434)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	1,535	0	0	0	0	0	0	0	0	1,535	23
24	Travel and Seminar	0	0	821	0	0	0	0	0	0	0	0	821	24
25	Other Admin. Staff Transportation	0	0	2,262	0	0	0	0	0	0	0	0	2,262	25
26	Insurance-Prop.Liab.Malpractice	0	0	1,095	0	0	0	0	0	0	0	0	1,095	26
27	Other (specify):*	0	(8,967)	51,336	0	0	0	0	0	0	0	0	42,369	27
28	TOTAL General Administration	(81,075)	(343,767)	192,031	0	(232,811)	28							
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(81,474)	(302,418)	176,196	0	(207,696)	29							

STATE OF ILLINOIS

Summary B

Facility Name & ID Number OAK PARK HEALTHCARE CENTER

0044602

Report Period Beginning:

01/01/2006

Ending:

12/31/2006

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	(39,243)	0	11,575	0	0	0	0	0	0	0	0	(27,668)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(7)	0	27,038	0	0	0	0	0	0	0	0	27,031	32
33	Real Estate Taxes	0	0	3,462	0	0	0	0	0	0	0	0	3,462	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	(15,977)	0	0	0	0	0	0	0	0	(15,977)	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(39,250)	0	26,098	0	(13,152)	37							
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	(26,165)	0	0	0	0	0	0	0	0	(26,165)	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	(26,165)	0	(26,165)	44							
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(120,724)	(302,418)	176,129	0	(247,013)	45							

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
				CAREPLUS MGMT	SKOKIE	MGMT/CLERICAL
				CAREPLUS REHABILITATIVE SERVICES		
SEE ATTACHED SCHEDULES					SKOKIE	THERAPY

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V		\$	CAREPLUS MGMT INC		\$		1
2	V	19 ADMIN. CONSULTANT FEES	198,000	" "			(198,000)	2
3	V	19 DATA PROCESSING FEES	14,400	" "			(14,400)	3
4	V	21 CLERICAL FEES	122,400	" "			(122,400)	4
5	V	27 W/C INSURANCE	8,967	" "			(8,967)	5
6	V			" "				6
7	V			" "				7
8	V	5 UTILITIES		" "		28	28	8
9	V	6 REPAIRS		" "		1,162	1,162	9
10	V	6 MAINTENANCE SALARIES		" "		3,490	3,490	10
11	V	7 SECURITY		" "		13	13	11
12	V	10 NURSING		" "		34,335	34,335	12
13	V	10a THERAPY SALARIES		" "		2,321	2,321	13
14	Total		\$ 343,767			\$ 41,349	\$ * (302,418)	14

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	17 ADMIN SALARIES	\$	CAREPLUS MGMT INC		\$ 77,480	\$ 77,480
16	V	19 PROFESSIONAL FEES		" "		2,577	2,577
17	V	20 DUES/LICENSES/WANT ADS		" "		1,875	1,875
18	V	21 OFFICE EXPENSES		" "		11,433	11,433
19	V	21 CLERICAL SALARIES		" "		41,617	41,617
20	V	23 SEMINARS		" "		1,535	1,535
21	V	24 TRAVEL		" "		821	821
22	V	25 TRANSPORTATION		" "		2,262	2,262
23	V	26 INSURANCE		" "		1,095	1,095
24	V	27 EMPLOYEE BENEFITS		" "		51,336	51,336
25	V	30 SL DEPRECIATION		" "		8,603	8,603
26	V	32 INTEREST		" "		25,005	25,005
27	V	33 REAL ESTATE TAX		" "		3,462	3,462
28	V	35 EQUIP RENT/AUTO LEASE		" "		6,423	6,423
29	V						
30	V	10a THERAPY SERVICES	131,103	CAREPLUS REHABILITATIVE SERVICES		115,268	(15,835)
31	V	39 ANCILLARY THERAPY	216,626	" "		190,461	(26,165)
32	V	35 EQUIPMENT RENT EXPENSE	22,400	" "			(22,400)
33	V	30 SL DEPRECIATION		" "		2,972	2,972
34	V	32 INTEREST		" "		2,033	2,033
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 370,129			\$ 546,258	\$ * 176,129

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

Facility Name & ID Number OAK PARK HEALTHCARE CENTER # 0044602 Report Period Beginning: 01/01/2006 Ending: 12/31/2006

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	CAREPLUS MGMT ALLOCATIONS:								\$		1
2	SHERWIN RAY	PRESIDENT	ADMIN/FINANCE	50.00	SEE ATTACHED	4.2	6.95	SALARY	13,899	17-7	2
3	JAKOB BAKST	DIR OPERAT'NS	ADMIN/CONS.	50.00	SCHEDULES	4.2	6.95	" "	13,899	17-7	3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 27,798		13

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

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

Facility Name & ID Number OAK PARK HEALTHCARE CENTER

0044602

Report Period Beginning:

01/01/2006

Ending: 2/31/2006

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1		CENSUS DAYS			\$	\$		\$	1
2	5	UTILITIES	553,205	13 FACILITIES	408		38,445	28	2
3	6	REPAIRS	553,205	13 FACILITIES	16,722		38,445	1,162	3
4	6	MAINTENANCE SALARIES	553,205	13 FACILITIES	50,215	50,215	38,445	3,490	4
5	7	SECURITY	553,205	13 FACILITIES	194		38,445	13	5
6	10	NURSING	553,205	13 FACILITIES	494,063	494,063	38,445	34,335	6
7	10a	THERAPY SALARIES	553,205	13 FACILITIES	33,400	33,400	38,445	2,321	7
8	17	ADMIN SALARIES	553,205	13 FACILITIES	1,114,897	1,114,897	38,445	77,480	8
9	19	PROFESSIONAL FEES	553,205	13 FACILITIES	37,085		38,445	2,577	9
10	20	DUES/LICENSES/WANT ADS	553,205	13 FACILITIES	26,974		38,445	1,875	10
11	21	OFFICE EXPENSES	553,205	13 FACILITIES	164,515		38,445	11,433	11
12	21	CLERICAL SALARIES	553,205	13 FACILITIES	598,842	598,842	38,445	41,617	12
13	23	SEMINARS	553,205	13 FACILITIES	22,090		38,445	1,535	13
14	24	TRAVEL	553,205	13 FACILITIES	11,815		38,445	821	14
15	25	TRANSPORTATION	553,205	13 FACILITIES	32,553		38,445	2,262	15
16	26	INSURANCE	553,205	13 FACILITIES	15,760		38,445	1,095	16
17	27	EMPLOYEE BENEFITS	553,205	13 FACILITIES	738,700		38,445	51,336	17
18	30	SL DEPRECIATION	553,205	13 FACILITIES	123,804		38,445	8,603	18
19	32	INTEREST	553,205	13 FACILITIES	359,819		38,445	25,005	19
20	33	REAL ESTATE TAX	553,205	13 FACILITIES	49,822		38,445	3,462	20
21	35	EQUIP RENT/AUTO LEASE	553,205	13 FACILITIES	92,424		38,445	6,423	21
22									22
23									23
24									24
25	TOTALS				\$ 3,984,102	\$ 2,291,417		\$ 276,873	25

Facility Name & ID Number

OAK PARK HEALTHCARE CENTER

0044602

Report Period Beginning:

01/01/2006

Ending:

12/31/2006

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	2	3	4	5	6	7	8	9	10											
										Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
											YES	NO				Original	Balance			
A. Directly Facility Related																				
Long-Term																				
1	CAREPLUS MANAGEMENT ALLOCATION: LOC, ETC				\$	\$			\$ 25,005	1										
2	CAREPLUS REHAB ALLOCATION: EQUIPMENT LOANS								2,033	2										
3										3										
4										4										
5	CAREPLUS MGT - FIRST BK	X	CAPITAL IMPROVEMENT	\$5,572.35	01/04	234,551	70,784	01/09	PRIME+	7,280	5									
Working Capital																				
6	CAREPLUS MGMT - HFG	X	WORKING CAPITAL	DEMAND	Jan-04	3,370,000	7,925,961		PRIME+	614,124	6									
7										7										
8										8										
9	TOTAL Facility Related			\$5,572.35		\$ 3,604,551	\$ 7,996,745			\$ 648,442	9									
B. Non-Facility Related*																				
10	IRS, IDR, ETC		X LATE FEES							4	10									
11											11									
12											12									
13											13									
14	TOTAL Non-Facility Related					\$ 0	\$ 0			\$ 4	14									
15	TOTALS (line 9+line14)					\$ 3,604,551	\$ 7,996,745			\$ 648,446	15									

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

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

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

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2005 report.		\$	293,820	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		\$	360,382	2
3. Under or (over) accrual (line 2 minus line 1).		\$	66,562	3
4. Real Estate Tax accrual used for 2006 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	363,990	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	430,552	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2001	324,378	8
	2002	274,833	9
	2003	269,947	10
	2004	290,912	11
	2005	360,382	12

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

THE PAYMENT ON LINE 2 APPLIES TO THE 2005 TAX BILL.

FOR BHF USE ONLY			
13	FROM R. E. TAX STATEMENT FOR 2005	\$	13
14	PLUS APPEAL COST FROM LINE 5	\$	14
15	LESS REFUND FROM LINE 6	\$	15
16	AMOUNT TO USE FOR RATE CALCULATION	\$	16

NOTES:

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

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2005 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 2005 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2005.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2005 real estate tax bill to Healthcare and Family Services, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2006 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.

2005 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME OAK PARK HEALTHCARE CENTER COUNTY COOK

FACILITY IDPH LICENSE NUMBER 0044602

CONTACT PERSON REGARDING THIS REPORT BOB KAGDA

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

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2005 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 2005.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>16-07-106-004-0000</u>	<u>NURSING HOME</u>	\$ <u>71,894.26</u>	\$ <u>71,894.26</u>
2. <u>16-07-106-005-0000</u>	<u>NURSING HOME</u>	\$ <u>69,488.18</u>	\$ <u>69,488.18</u>
3. <u>16-07-106-022-0000</u>	<u>NURSING HOME</u>	\$ <u>218,999.62</u>	\$ <u>218,999.62</u>
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>360,382.06</u>	\$ <u>360,382.06</u>

B. Real Estate Tax Cost Allocations

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

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

C. Tax Bills

Attach a copy of the original 2005 tax bills which were listed in Section A to this statement. Be sure to use the 2005 tax bill which is normally paid during 2006.

PLEASE NOTE: Payment information from the Internet or otherwise is not considered acceptable tax bill documentation. Facilities located in Cook County are required to provide copies of their original **second installment** tax bill.

Facility Name & ID Number OAK PARK HEALTHCARE CENTER

0044602

Report Period Beginning:

01/01/2006 Ending:

12/31/2006

X. BUILDING AND GENERAL INFORMATION:

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

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

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

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

N/A

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 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	<u>NURSING HOME</u>	<u>22,950</u>		\$	<u>1</u>
2					<u>2</u>
3	TOTALS	22,950		\$ 0	3

Facility Name & ID Number OAK PARK HEALTHCARE CENTER

0044602

Report Period Beginning:

01/01/2006 Ending: 12/31/2006

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

1	2	3	4	5	6	7	8	9		
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4				\$	\$		\$	\$	\$	4
5										5
6										6
7										7
8										8
	Improvement Type**									
9	NEW WINDOWS / LIGHT FIXTURES / GENERATOR		1999	74,653	1,914	39	1,914		13,493	9
10	WINDOWS / FENCE / CEILING		2000	13,360	486	27.5	486		3,382	10
11	WINDOWS / SIGNS / FLOORING / WALLPAPER		2000	42,672	1,552	27.5	1,552		10,643	11
12	WINDOWS / FLOORING / WALLPAPER / NURSE STATION		2000	29,709	1,080	27.5	1,080		7,245	12
13	FLOORING / DOORS / WALLS / HVAC SYSTEM		2000	56,310	2,047	27.5	2,047		13,562	13
14	WINDOWS / FLOORING / RAILS / ASPHALT PAVING		2000	30,160	1,096	27.5	1,096		7,130	14
15	WINDOWS / PLUMBING / PAINTING & DECORATING		2000	41,459	1,508	27.5	1,508		9,436	15
16	WINDOW TREATMENTS		2000	15,445	1,379	15	1,030	(349)	6,695	16
17	WINDOWS/WALK-IN FREEZER, ROOF & A/C REPAIRS		2001	23,850	868	27.5	868		4,932	17
18	WINDOWS//FLOORING/ALARM & PAGING SYSTEM		2001	9,926	361	27.5	361		1,843	18
19	WINDOWS/DOORS/GREASE TRAP/ROOF A/C		2002	62,212	2,266	27.5	2,266		10,203	19
20	WINDOWS/BACKFLOW PREVENTORS/AC TOWER BEARING		2003	16,526	603	27.5	603		2,267	20
21	CIRCUITS/ROOFTOP A/C MOTORS		2004	3,382	123	27.5	123		324	21
22	WINDOWS		2004	7,200	262	27.5	262		588	22
23	REMODEL MOLDINGS/HANDRAILS/CABINETRY/DECOR		2004	68,233	2,480	27.5	2,480		5,629	23
24	LIGHTING/NSG STNS/BATHRMS/FLOORS/RAILS/MOLDINGS		2005	321,276	11,683	27.5	11,683		14,838	24
25	WINDOWS/DOORS/ROOF/SIDING/PORCH/PATIO		2005	164,807	5,993	27.5	5,993		8,040	25
26	LANDSCAPING		2005	16,610	1,108	15	1,108		1,661	26
27	ROOM SIGNS/HAND RAILS/LIGHTING/EXHAUST/TILE		2006	22,383	603	27.5	603		286	27
28										28
29										29
30	RELATED PARTY ALLOCATION - CAREPLUS REHAB									30
31	DOORS		2004	4,150	106	39	106		314	31
32										32
33										33
34	RELATED PARTY ALLOCATION - CAREPLUS MGMT									34
35	BUILDING-TAG-18 PROPERTIES		2004	41,189	1,115	39	1,115		2,171	35
36	BUILDING IMPROVEMENTS-TAG-18 PROPERTIES		2004	16,182	660	39	660		1,283	36

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

See Page 12A, Line 70 for total

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

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67								67
68								68
69								69
70	TOTAL (lines 4 thru 69)	\$ 1,081,694	\$ 39,293		\$ 38,944	\$ (349)	\$ 125,965	70

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

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 241,035	\$ 55,770	\$ 17,947	\$ (37,823)	8-15 YRS	\$ 65,670	71
72	Current Year Purchases	7,162	1,433	362	(1,071)	8-15 YRS	362	72
73	Fully Depreciated Assets				0			73
74	** RELATED PARTY - SL DEPN: CAREPLUS MGMT, 6,828, CAREPLUS REHAB, 2,866		9,694	9,694	0	8-15 YRS		74
75	TOTALS	\$ 248,197	\$ 66,897	\$ 28,003	\$ (38,894)		\$ 66,032	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				\$	\$	\$	0		\$	76
77							0			77
78							0			78
79							0			79
80	TOTALS			\$ 0	\$ 0	\$ 0	0		\$ 0	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 1,329,891	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 106,190	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 66,947	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (39,243)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 191,997	85

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

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

G. Construction-in-Progress

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

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: **FAIRMOUNT OF OAK PARK LLC**

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

If NO, see instructions. YES NO

	1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:	204	11/01/99	\$ 692,879			3
4	Additions						4
5							5
6							6
7	TOTAL	204		\$ 692,879			7

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

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

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

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

15. Is Movable equipment rental included in building rental?

YES NO

16. Rental Amount for movable equipment: \$ **47,553** Description: **SEE SCHEDULE ATTACHED**

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	ACTIVITY/HSKP/	2003 CHEVY EXPR 15P	\$	\$ 6,023	17
18	MAINT				18
19	MGMT CO ALLOC-SEE ATTACHED			3,157	19
20					20
21	TOTAL		\$	\$ 9,180	21

10. Effective dates of current rental agreement:

Beginning 11/01/99

Ending _____

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

Fiscal Year Ending Annual Rent

12. /2007 \$ _____

13. /2008 \$ _____

14. /2009 \$ _____

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

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

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility		Contract	Total
		1 Drop-outs	2 Completed		
1	Community College Tuition	\$	\$	\$	\$ 0
2	Books and Supplies				0
3	Classroom Wages (a)				0
4	Clinical Wages (b)				0
5	In-House Trainer Wages (c)				0
6	Transportation				0
7	Contractual Payments				0
8	CNA Competency Tests				0
9	TOTALS	\$ 0	\$ 0	\$ 0	\$ 0
10	SUM OF line 9, col. 1 and 2 (e)	\$ 0			

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39-3	hrs	\$		\$ 69,206	\$		\$ 69,206	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			30,344			30,344	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			112,960			112,960	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program	39-2/39-3				4,117	37,508		41,625	12
13	MED.SUPPLIES/LAB/RENTALS Other (specify):	39-2					106,996		106,996	13
14	TOTAL			\$		\$ 216,627	\$ 144,504		\$ 361,131	14

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

Facility Name & ID Number OAK PARK HEALTHCARE CENTER

0044602

Report Period Beginning: 01/01/2006

Ending:

12/31/2006

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2006

(last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>115,000</u>)	2,442,207		3
4	Supply Inventory (priced at _____)			4
5	Short-Term Investments			5
6	Prepaid Insurance	67,815		6
7	Other Prepaid Expenses	17,108		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>R.E.TAX ESCROW</u>	96,537		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,623,667	\$ 0	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	1,005,285		15
16	Equipment, at Historical Cost	263,085		16
17	Accumulated Depreciation (book methods)	(297,138)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify: <u>DUE FROM LLC</u>)	13,734		22
23	Other(specify): <u>SECURITY DEPOSITS</u>	22,478		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,007,444	\$ 0	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 3,631,111	\$ 0	25

		1	2	
		Operating	After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 969,413	\$	26
27	Officer's Accounts Payable	150,000		27
28	Accounts Payable-Patient Deposits	32,615		28
29	Short-Term Notes Payable	7,996,745		29
30	Accrued Salaries Payable	101,848		30
31	Accrued Taxes Payable (excluding real estate taxes)	17,124		31
32	Accrued Real Estate Taxes(Sch.IX-B)	363,990		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 9,631,735	\$ 0	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
Other Long-Term Liabilities(specify):				
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 0	\$ 0	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 9,631,735	\$ 0	46
47	TOTAL EQUITY(page 18, line 24)	\$ (6,000,624)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 3,631,111	\$ 0	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (4,353,557)	1
2	Restatements (describe):		2
3	ROUNDING	2	3
4	POST-CLOSING INTEREST ADJUSTMENT	252,838	4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (4,100,717)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(1,899,907)	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)	\$ (1,899,907)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$ 0	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ (6,000,624)	24 *

* This must agree with page 17, line 47.

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

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

1

	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 4,959,968	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,959,968	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 0	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 0	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	3	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 3	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 0	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 4,959,971	30

2

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	920,325	31
32	Health Care	2,176,667	32
33	General Administration	1,351,193	33
	B. Capital Expense		
34	Ownership	1,896,187	34
	C. Ancillary Expense		
35	Special Cost Centers	361,131	35
36	Provider Participation Fee	111,690	36
	D. Other Expenses (specify):		
37	OUT-OF-PERIOD EXPENSES	42,685	37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 6,859,878	40
41	Income before Income Taxes (line 30 minus line 40)**	(1,899,907)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (1,899,907)	43

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

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

TAX RETURN PREPARED ON CASH BASIS

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

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

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

0044602

Report Period Beginning: **01/01/2006**

Ending:

12/31/2006

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	1,938	2,052	\$ 66,721	\$ 32.52	1
2	Assistant Director of Nursing	1,413	1,464	42,502	29.03	2
3	Registered Nurses	8,870	9,382	261,489	27.87	3
4	Licensed Practical Nurses	24,244	25,006	588,888	23.55	4
5	CNAs & Orderlies	64,646	71,491	729,206	10.20	5
6	CNA Trainees					6
7	Licensed Therapist	262	266	6,676	25.10	7
8	Rehab/Therapy Aides	6,061	6,705	68,791	10.26	8
9	Activity Director	1,933	2,178	23,194	10.65	9
10	Activity Assistants	5,026	5,551	47,297	8.52	10
11	Social Service Workers	4,245	4,482	89,106	19.88	11
12	Dietician					12
13	Food Service Supervisor	2,148	2,242	34,543	15.41	13
14	Head Cook	4,987	5,459	64,632	11.84	14
15	Cook Helpers/Assistants	9,493	10,214	84,773	8.30	15
16	Dishwashers					16
17	Maintenance Workers	4,361	4,576	43,398	9.48	17
18	Housekeepers	14,374	15,849	154,451	9.75	18
19	Laundry	5,776	6,538	63,480	9.71	19
20	Administrator	1,979	2,104	84,644	40.23	20
21	Assistant Administrator	1,760	1,786	29,566	16.55	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	4,232	4,563	42,067	9.22	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	1,910	1,996	23,189	11.62	31
32	Other Health Care(specify)					32
33	Other(specify) <u>MARKETING</u>	1,060	1,069	19,957	18.67	33
34	TOTAL (lines 1 - 33)	170,718	184,973	\$ 2,568,570 *	\$ 13.89	34

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

** See instructions.

B. CONSULTANT SERVICES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference		
35	Dietary Consultant	M	\$ 11,007	1-3	35
36	Medical Director	O	4,500	9-3	36
37	Medical Records Consultant	N	1,440	10-3	37
38	Nurse Consultant	T	0	10-3	38
39	Pharmacist Consultant	H	1,800	10-3	39
40	Physical Therapy Consultant	L	7,200	10a-3	40
41	Occupational Therapy Consultant	Y	7,200	10a-3	41
42	Respiratory Therapy Consultant		0	10a-3	42
43	Speech Therapy Consultant	F	0	10a-3	43
44	Activity Consultant	E	888	11-3	44
45	Social Service Consultant	E	28	12-3	45
46	Other(specify)	S			46
47	<u>PSYCHIATRIC</u>		0	10-3	47
48	<u>M/C & PA CONSULTING</u>		0	10-3	48
49	TOTAL (lines 35 - 48)		\$ 34,063		49

C. CONTRACT NURSES

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

Facility Name & ID Number OAK PARK HEALTHCARE CENTER

0044602

Report Period Beginning: 01/01/2006

Ending: 12/31/2006

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? YES
- (2) Are there any dues to nursing home associations included on the cost report? YES
If YES, give association name and amount. IL ASSOC HEALTHCARE FACIL \$
- (3) Did the nursing home make political contributions or payments to a political action organization? YES If YES, have these costs been properly adjusted out of the cost report? YES
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? YES
What was the average life used for new equipment added during this period? 10 YR
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 511 Line 10-2
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? NO
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? _____ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 111,690
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? NO If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? YES
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? NO For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 14,235 Has any meal income been offset against related costs? N/A Indicate the amount. \$ _____
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? NO
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? 5%
d. Have vehicle usage logs been maintained? NO
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? NO
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? YES
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? NO
Firm Name: _____ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? _____ If no, please explain. _____
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? YES
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? YES
Attach invoices and a summary of services for all architect and appraisal fees