

		FOR BHF USE					

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2006
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2006)

IMPORTANT NOTICE
 THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

<p>I. IDPH Facility ID Number: <u>0034991</u></p> <p>Facility Name: <u>PARK HOUSE</u></p> <p>Address: <u>2320 SOUTH LAWNDALE</u> <u>CHICAGO</u> <u>60623</u> Number City Zip Code</p> <p>County: <u>COOK</u></p> <p>Telephone Number: <u>(847) 329-1555</u> Fax # <u>(847) 329-9555</u></p> <p>HFS ID Number: <u>36-3620976</u></p> <p>Date of Initial License for Current Owners: <u>1/1/1989</u></p> <p>Type of Ownership:</p> <table border="0"> <tr> <td><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input type="checkbox"/> PROPRIETARY</td> <td><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td>IRS Exemption Code _____</td> <td><input type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input checked="" type="checkbox"/> "Sub-S" Corp.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Limited Liability Co.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other _____</td> <td></td> </tr> </table> <p>In the event there are further questions about this report, please contact: Name: <u>BOB KAGDA</u> Telephone Number: <u>(847) 675-3585</u></p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input 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 _____		<p>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/2006</u> to <u>12/31/2006</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="1"> <tr> <td rowspan="2" style="width: 15%;">Officer or Administrator of Provider</td> <td>(Signed) _____</td> <td>(Date) _____</td> </tr> <tr> <td>(Type or Print Name) <u>SHERWIN I. RAY</u></td> <td></td> </tr> <tr> <td></td> <td>(Title) <u>PRESIDENT</u></td> <td></td> </tr> <tr> <td rowspan="4" style="width: 15%;">Paid Preparer</td> <td>(Signed) <u>(SEE ATTACHED ACCOUNTANTS' REPORT)</u></td> <td>(Date) _____</td> </tr> <tr> <td>(Print Name and Title) <u>BOB KAGDA</u> <u>VICE PRESIDENT</u></td> <td></td> </tr> <tr> <td>(Firm Name & Address) <u>KRUPNICK, BOKOR, KAGDA & BROOKS, LTD</u> <u>3750 W DEVON, LINCOLNWOOD, IL 60712-1124</u></td> <td></td> </tr> <tr> <td>(Telephone) <u>(847) 675-3585</u> Fax # <u>(847) 675-5777</u></td> <td></td> </tr> </table> <p align="right">MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630</p>	Officer or Administrator of Provider	(Signed) _____	(Date) _____	(Type or Print Name) <u>SHERWIN I. RAY</u>			(Title) <u>PRESIDENT</u>		Paid Preparer	(Signed) <u>(SEE ATTACHED ACCOUNTANTS' REPORT)</u>	(Date) _____	(Print Name and Title) <u>BOB KAGDA</u> <u>VICE PRESIDENT</u>		(Firm Name & Address) <u>KRUPNICK, BOKOR, KAGDA & BROOKS, LTD</u> <u>3750 W DEVON, LINCOLNWOOD, IL 60712-1124</u>		(Telephone) <u>(847) 675-3585</u> Fax # <u>(847) 675-5777</u>	
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Facility Name & ID Number PARK HOUSE

0034991 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	14	Skilled (SNF)	14	5,110	1
2		Skilled Pediatric (SNF/PED)			2
3	92	Intermediate (ICF)	92	33,580	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	106	TOTALS	106	38,690	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF			1,890	1,890	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD	29,110			29,110	11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	29,110		1,890	31,000	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 80.12%

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 01/01/89

J. Was the facility purchased or leased after January 1, 1978?
YES Date 01/01/89 NO

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified _____ and days of care provided 1,890

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 **PARK HOUSE** # **0034991** 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	158,151	18,875	6,554	183,580		183,580	0	183,580		1
2	Food Purchase		129,760		129,760	0	129,760	(266)	129,494		2
3	Housekeeping	127,929	20,860	0	148,789		148,789	0	148,789		3
4	Laundry	34,574	17,114	0	51,688	0	51,688	0	51,688		4
5	Heat and Other Utilities			91,060	91,060		91,060	23	91,083		5
6	Maintenance	26,188	17,056	28,041	71,285		71,285	3,763	75,048		6
7	Other (specify):*			12,757	12,757		12,757	11	12,768		7
8	TOTAL General Services	346,842	203,665	138,412	688,919	0	688,919	3,531	692,450		8
	B. Health Care and Programs										
9	Medical Director	0		14,600	14,600		14,600	0	14,600		9
10	Nursing and Medical Records	875,760	35,469	40,878	952,107		952,107	(10,962)	941,145		10
10a	Therapy	26,168	7,938	88,644	122,750		122,750	(8,826)	113,924		10a
11	Activities	62,766	14,885	3,754	81,405		81,405	0	81,405		11
12	Social Services	168,402		0	168,402		168,402	0	168,402		12
13	CNA Training			0	0		0	0	0		13
14	Program Transportation			0	0		0	0	0		14
15	Other (specify):*			0	0		0	0	0		15
16	TOTAL Health Care and Programs	1,133,096	58,292	147,876	1,339,264	0	1,339,264	(19,788)	1,319,476		16
	C. General Administration										
17	Administrative	64,269		303,600	367,869		367,869	(156,917)	210,952		17
18	Directors Fees			0	0		0	0	0		18
19	Professional Services			220,549	220,549		220,549	(165,915)	54,634		19
20	Dues, Fees, Subscriptions & Promotions			59,612	59,612		59,612	(6,120)	53,492		20
21	Clerical & General Office Expenses	154,201	12,749	139,282	306,232		306,232	(74,074)	232,158		21
22	Employee Benefits & Payroll Taxes			314,376	314,376	0	314,376	0	314,376		22
23	Inservice Training & Education			1,088	1,088		1,088	1,242	2,330		23
24	Travel and Seminar			0	0		0	664	664		24
25	Other Admin. Staff Transportation			8,746	8,746		8,746	1,830	10,576		25
26	Insurance-Prop.Liab.Malpractice			47,506	47,506		47,506	886	48,392		26
27	Other (specify):*			0	0		0	34,790	34,790		27
28	TOTAL General Administration	218,470	12,749	1,094,759	1,325,978	0	1,325,978	(363,614)	962,364		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,698,408	274,706	1,381,047	3,354,161	0	3,354,161	(379,871)	2,974,290		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	6,554
	REPAIRS & MAINTENANCE	0
		0
		6,554
3	HOUSEKEEPING	
		0
		0
		0
4	LAUNDRY	
	EQUIPMENT REPAIRS & MAINTENANCE	0
		0
		0
5	HEAT & OTHER UTILITIES	
	GAS HEAT	45,441
	ELECTRICITY	31,283
	WATER	12,662
	CABLE TV - LOBBY	1,674
		0
		91,060
6	MAINTENANCE	
	GROUNDS MAINTENANCE	0
	PAINTING & DECORATING	0
	BUILDING REPAIRS	0
	MAINTENANCE TRAVEL	0
	EQUIPMENT MAINTENANCE & REPAIR	12,438
	ELEVATOR MAINTENANCE & REPAIR	7,192
	OUTSIDE LABOR	800
	EXTERMINATING SERVICE	3,648
	FIRE SERVICE	3,963
		0
		0
		0
		0
		28,041
7	OTHER	
	SCAVENGER	12,757
	SECURITY SERVICE	0
		0
		0
		12,757
9	MEDICAL DIRECTOR	
	MEDICAL DIRECTOR FEES XVIII B 36-2	14,600
		14,600

LINE	SCHED REF	TOTAL
10	NURSING	
	CONTRACT NURSING XVIII C 53-2	
	LABORATORY & XRAY EXPENSE	0
	PURCHASED SERVICES	158
	PSYCHO-SOCIAL CONSULTANT XVIII B ___-2	0
	RESTORATIVE NURSING CONSULTANT XVIII B 38-2	0
	MEDICAL RECORDS CONSULTANT XVIII B 37-2	1,080
	PHARMACY CONSULTANT XVIII B 39-2	900
	UTILIZATION REVIEW FEES XVIII B ___-2	0
	PHYSICIANS XVIII B ___-2	0
	PSYCHIATRIC XVIII B ___-2	0
	RN CONSULTANT XVIII B 38-2	0
	PROGRAM CONSULTANT	38,740
		0
		40,878
10a	THERAPY	
	PHYSICAL THERAPY SERVICES	3,713
	SPEECH THERAPY SERVICES	918
	OCCUPATIONAL THERAPY SERVICES	378
	REHABILITATION CONSULTANT XVIII B ___-2	0
	PHYSICAL THERAPY CONSULTANT XVIII B 40-2	5,400
	OCCUPATIONAL THERAPY CONSULTA XVIII B 41-2	5,400
	RESPIRATORY THERAPY CONSULTAN XVIII B 42-2	0
	SPEECH THERAPY CONSULTANT XVIII B 43-2	0
	THERAPY CONTRACT SERVICES	72,835
		88,644
11	ACTIVITIES	
	CABLE TV - PATIENT ROOMS	0
	ACTIVITY REHAB CONSULTANT XVIII B 44-2	3,754
		0
		3,754
12	SOCIAL SERVICES	
	SOCIAL REHABILITATION SERVICES	0
	SOCIAL REHABILITATION CONSULTAN XVIII B 45-2	0
	SOCIAL WORKER XVIII B 45-2	0
		0
		0
13	NURSE AIDE TRAINING	
	NURSE AIDE TRAINING COSTS XIII	0
		0

V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE	SCHED REF	TOTAL
14	PROGRAM TRANSPORTATION	
	PATIENT TRANSPORTATION	0
17	ADMINISTRATIVE	
	MANAGEMENT FEES XIX B	303,600
	DIRECTORS FEES	
18	DIRECTORS FEES	0
19	PROFESSIONAL SERVICES	
	DATA PROCESSING XIX C	24,530
	ADMINISTRATIVE CONSULTANTS XIX C	156,000
	PROFESSIONAL FEES XIX C	40,019
		0
		220,549
20	FEES,SUBSCRIPTIONS,PROMOTIONS	
	ENTERTAINMENT & MARKETING VI 19 XIX F	0
	ADV & PROMO-NON PATIENT RELATED VI 25 XIX F	7,337
	EMPLOYEE WANT ADS XIX F	45,071
	CONTRIBUTIONS VI 20 XIX F	0
	DUES & SUBSCRIPTIONS XIX F	742
	LICENSES & PERMITS XIX F	5,968
	PUBLIC RELATIONS-PATIENT RELATED XIX F	0
	ADVERTISING-YELLOW PAGES VI 28 XIX F	0
	TRUST FEES / FRANCHISE TAX / ETC VI 17 XIX F	0
	CONTRIBUTIONS - POLITICAL VI 20 XIX F	300
	HEALTH CARE WORKER BACKGROUND CHEC XIX F	194
	PATIENT BACKGROUND CHECKS XIX F	0
		59,612
21	CLERICAL & GENERAL OFFICE EXPENSES	
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)	0
	EQUIPMENT REPAIR & MAINTENANCE	7,377
	OUTSIDE CLERICAL SERVICES	99,745
	PENALTIES / OVERDRAFT CHARGES VI 18	17,248
	HOME OFFICE EXPENSE	0
	THEFT & DAMAGE LOSS	0
	TELEPHONE	13,416
	MESSENGER SERVICE	1,496
		0
		139,282

LINE	SCHED REF	TOTAL
22	EMPLOYEE BENEFITS & PAYROLL TAXES	
	FICA TAXES XIX D	129,510
	UNEMPLOYMENT COMPENSATION XIX D	53,597
	WORKERS COMPENSATION INSURANC XIX D	62,706
	HOSPITALIZATION INSURANCE XIX D	46,575
	EMPLOYEE BENEFITS - OTHER XIX D	19,128
	EMPLOYEE PHYSICAL EXAMS XIX D	0
	INSURANCE - EXECUTIVE LIFE VI 21/XIX D	0
	PENSION/PROFIT SHARING PLANS XIX D	0
	CHICAGO HEAD TAX XIX D	2,860
		0
		314,376
23	INSERVICE TRAINING & EDUCATION	
	EDUCATION & SEMINARS	1,088
		1,088
24	TRAVEL & SEMINARS	
	EDUCATION & SEMINARS XIX G	0
	TRAVEL XIX G	0
		0
25	ADMIN. STAFF TRANSPORTATION	
	TRANSPORTATION - STAFF	8,746
		8,746
26	INSURANCE - PROP. LIAB & MALPRACTICE	
	GENERAL INSURANCE	47,506
		47,506
27	OTHER	
	BAD DEBTS VI 24	0
		0

GRAND TOTAL COLUMN 3 OTHER

1,381,047

PARK HOUSE
 EMPLOYEE MEAL RECLASSIFICATION (PAGE 3 SCHEDULE V COLUMN 5 LINES 2 AND 22)
 12/31/2006

TOTAL FOOD PURCHASE	129,760	PATIENT MEALS	93000
LESS SALES TAX	(266)	ADD EMPLOYEE MEALS	0
	-----		-----
NET FOOD	129,494	TOTAL MEALS/YEAR	93000
TOTAL PATIENT CENSUS	31,000	NET FOOD	129494
TIME 3 MEALS PER DAY	3	DIVIDE TOTAL MEALS/YEAR	93000

TOTAL PATIENT MEALS	93000	COST PER MEAL	1.39
		TIME EMPLOYEE MEALS	0

ADD # EMPLOYEE MEALS/DAY		EMPLOYEE MEAL RECLASSIFICATION	0
TIME # DAYS	365		=====

TOTAL EMPLOYEE MEALS	0		

Facility Name & ID Number **PARK HOUSE**

#0034991

Report Period Beginning:

01/01/2006

Ending:

12/31/2006

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			34,591	34,591		34,591	52,176	86,767			30
31	Amortization of Pre-Op. & Org.			0	0		0	0	0			31
32	Interest			46	46		46	265,689	265,735			32
33	Real Estate Taxes			81,992	81,992		81,992	2,801	84,793			33
34	Rent-Facility & Grounds			351,102	351,102		351,102	(343,660)	7,442			34
35	Rent-Equipment & Vehicles			39,317	39,317		39,317	(14,927)	24,390			35
36	Other (specify):*				0		0	0	0			36
37	TOTAL Ownership			507,048	507,048	0	507,048	(37,921)	469,127			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation				0		0	0	0			38
39	Ancillary Service Centers		41,935	85,483	127,418		127,418	(10,325)	117,093			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			58,035	58,035		58,035	0	58,035			42
43	Other (specify):*				0		0	0	0			43
44	TOTAL Special Cost Centers	0	41,935	143,518	185,453	0	185,453	(10,325)	175,128			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,698,408	316,641	2,031,613	4,046,662	0	4,046,662	(428,117)	3,618,545			45

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

Facility Name & ID Number **PARK HOUSE**

0034991

Report Period Beginning:

01/01/2006

Ending:

12/31/2006

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	(580)	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(266)	2		13
14	Non-Care Related Interest	(46)	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees	0	20		17
18	Fines and Penalties	(17,248)	21		18
19	Entertainment	0	20		19
20	Contributions	(300)	20		20
21	Owner or Key-Man Insurance	0	22		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	0	27		24
25	Fund Raising, Advertising and Promotional	(7,337)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	0	20		28
29	Other-Attach Schedule	0			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (25,777)		\$ 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)	(402,340)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (402,340)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (428,117)		37

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

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

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

PARK HOUSE

ID# 0034991

Report Period Beginning: 01/01/2006

Ending: 12/31/2006

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
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			25
26			26
27			27
28			28
29			29
30			30
31			31
32			32
33			33
34			34
35			35
36			36
37			37
38			38
39			39
40			40
41			41
42			42
43			43
44			44
45			45
46			46
47			47
48			48
49	Total	0	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number PARK HOUSE# 0034991

Report Period Beginning:

01/01/2006

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	(266)	0	0	0	0	0	0	0	0	0	0	(266)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	23	0	0	0	0	0	0	0	23	5
6	Maintenance	0	0	0	3,763	0	0	0	0	0	0	0	3,763	6
7	Other (specify):*	0	0	0	11	0	0	0	0	0	0	0	11	7
8	TOTAL General Services	(266)	0	0	3,797	0	3,531	8						
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	(38,740)	27,778	0	0	0	0	0	0	0	(10,962)	10
10a	Therapy	0	(10,704)	0	1,878	0	0	0	0	0	0	0	(8,826)	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	(10,704)	(38,740)	29,656	0	(19,788)	16						
	C. General Administration													
17	Administrative	0	0	(219,600)	62,683	0	0	0	0	0	0	0	(156,917)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	(168,000)	2,085	0	0	0	0	0	0	0	(165,915)	19
20	Fees, Subscriptions & Promotions	(7,637)	0	0	1,517	0	0	0	0	0	0	0	(6,120)	20
21	Clerical & General Office Expenses	(17,248)	0	(99,745)	42,919	0	0	0	0	0	0	0	(74,074)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	1,242	0	0	0	0	0	0	0	1,242	23
24	Travel and Seminar	0	0	0	664	0	0	0	0	0	0	0	664	24
25	Other Admin. Staff Transportation	0	0	0	1,830	0	0	0	0	0	0	0	1,830	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	886	0	0	0	0	0	0	0	886	26
27	Other (specify):*	0	0	(6,742)	41,532	0	0	0	0	0	0	0	34,790	27
28	TOTAL General Administration	(24,885)	0	(494,087)	155,358	0	(363,614)	28						
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(25,151)	(10,704)	(532,827)	188,811	0	(379,871)	29						

STATE OF ILLINOIS

Summary B

Facility Name & ID Number PARK HOUSE# 0034991

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	(580)	45,796	0	6,960	0	0	0	0	0	0	0	52,176	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(46)	245,504	0	20,231	0	0	0	0	0	0	0	265,689	32
33	Real Estate Taxes	0	0	0	2,801	0	0	0	0	0	0	0	2,801	33
34	Rent-Facility & Grounds	0	(343,660)	0	0	0	0	0	0	0	0	0	(343,660)	34
35	Rent-Equipment & Vehicles	0	(20,123)	0	5,196	0	0	0	0	0	0	0	(14,927)	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(626)	(72,483)	0	35,188	0	(37,921)	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	(10,325)	0	0	0	0	0	0	0	0	0	(10,325)	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	(10,325)	0	0	0	0	0	0	0	0	0	(10,325)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(25,777)	(93,512)	(532,827)	223,999	0	(428,117)	45						

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
SCHEDULE ATTACHED		SCHEDULE ATTACHED		CAREPLUS MGMT	SKOKIE	MGMT/CLERICAL
				CAREPLUS REHABILITATIVE SERVICES		
					SKOKIE	THERAPY
				2320 S LAWNSDALE	SKOKIE	REAL ESTATE

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	34 RENT	\$ 343,660	2320 S LAWNSDALE LLC		\$	\$ (343,660)	1
2	V	30 SL DEPRECIATION		" "		43,185	43,185	2
3	V	32 INTEREST		" "		242,398	242,398	3
4	V							4
5	V							5
6	V	10a THERAPY SERVICES	88,621	CAREPLUS REHABILITATIVE SERVICES		77,917	(10,704)	6
7	V	39 ANCILLARY SERVICES	85,482	" "		75,157	(10,325)	7
8	V	35 EQUIPMENT RENT	20,123	" "			(20,123)	8
9	V	30 DEPRECIATION		" "		2,611	2,611	9
10	V	32 INTEREST		" "		3,106	3,106	10
11	V							11
12	V							12
13	V							13
14	Total		\$ 537,886			\$ 444,374	\$ * (93,512)	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	10 PROGRAM CONSULTANT	\$ 38,740	CAREPLUS MGMT INC	100.00%	\$	\$ (38,740) 15
16	V	17 MANAGEMENT FEE	219,600	" "			(219,600) 16
17	V	19 ADMIN CONSULTANT	156,000	" "			(156,000) 17
18	V	19 DATA PROCESSING	12,000	" "			(12,000) 18
19	V	21 CLERICAL FEES	99,745	" "			(99,745) 19
20	V	27 W/C INSURANCE	6,742	" "			(6,742) 20
21	V						
22	V						
23	V						
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 532,827			\$ 0	\$ * (532,827) 39

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

Facility Name & ID Number PARK HOUSE# 0034991Report Period Beginning: 01/01/2006 Ending: 12/31/2006

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	\$	CAREPLUS MGMT INC	100.00%	\$ 23	\$	23	15
16	V	6 MAINT & REPAIRS		" " "		940		940	16
17	V	6 MAINTENANCE SALARIES		" " "		2,823		2,823	17
18	V	7 SECURITY		" " "		11		11	18
19	V	10 NURSING SALARIES		" " "		27,778		27,778	19
20	V	10a THERAPY SALARIES		" " "		1,878		1,878	20
21	V	17 ADMIN SALARIES		" " "		62,683		62,683	21
22	V	19 PROFESSIONAL FEES		" " "		2,085		2,085	22
23	V	20 ADVERTISING		" " "		1,517		1,517	23
24	V	21 OFFICE EXPENSE		" " "		9,250		9,250	24
25	V	21 OFFICE SALARIES		" " "		33,669		33,669	25
26	V	23 SEMINARS		" " "		1,242		1,242	26
27	V	24 TRAVEL		" " "		664		664	27
28	V	25 TRANSPORTATION		" " "		1,830		1,830	28
29	V	26 INSURANCE		" " "		886		886	29
30	V	27 EMPLOYEE BENEFITS		" " "		41,532		41,532	30
31	V	30 DEPRECIATION		" " "		6,960		6,960	31
32	V	33 REAL ESTATE TAX		" " "		2,801		2,801	32
33	V	32 INTEREST		" " "		20,231		20,231	33
34	V	35 EQUIPMENT RENT		" " "		5,196		5,196	34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total		\$			\$ 223,999	\$ *	223,999	39

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

Facility Name & ID Number

PARK HOUSE

0034991

Report Period Beginning:

01/01/2006

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	JAKOB BAKST				SEE ATTACHED			SALARY	11,245	17-7	2
3	SHERWIN I RAY				SCHEDULE			SALARY	11,245	17-7	3
4	ERIC ROTHNER							MGMT FEE	84,000	17-3	4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 106,490		13

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

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

Facility Name & ID Number **PARK HOUSE**

0034991 Report Period Beginning: **01/01/2006**

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	5	UTILITIES	PATIENT DAYS	553,205	13	\$ 408	31,103	\$ 23	1
2	6	MAINT & REPAIRS	" " "	553,205	13	16,722	31,103	940	2
3	6	MAINTENANCE SALARIES	" " "	553,205	13	50,215	31,103	2,823	3
4	7	SECURITY	" " "	553,205	13	194	31,103	11	4
5	10	NURSING SALARIES	" " "	553,205	13	494,063	31,103	27,778	5
6	10a	THERAPY SALARIES	" " "	553,205	13	33,400	31,103	1,878	6
7	17	ADMIN SALARIES	" " "	553,205	13	1,114,897	31,103	62,683	7
8	19	PROFESSIONAL FEES	" " "	553,205	13	37,085	31,103	2,085	8
9	20	ADVERTISING	" " "	553,205	13	26,974	31,103	1,517	9
10	21	OFFICE EXPENSE	" " "	553,205	13	164,515	31,103	9,250	10
11	21	OFFICE SALARIES	" " "	553,205	13	598,842	31,103	33,669	11
12	23	SEMINARS	" " "	553,205	13	22,090	31,103	1,242	12
13	24	TRAVEL	" " "	553,205	13	11,815	31,103	664	13
14	25	TRANSPORTATION	" " "	553,205	13	32,553	31,103	1,830	14
15	26	INSURANCE	" " "	553,205	13	15,760	31,103	886	15
16	27	EMPLOYEE BENEFITS	" " "	553,205	13	738,700	31,103	41,532	16
17	30	DEPRECIATION	" " "	553,205	13	123,804	31,103	6,960	17
18	33	REAL ESTATE TAX	" " "	553,205	13	49,822	31,103	2,801	18
19	32	INTEREST	" " "	553,205	13	359,819	31,103	20,231	19
20	35	EQUIPMENT RENT	" " "	553,205	13	92,424	31,103	5,196	20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 3,984,102	\$ 2,291,417		\$ 223,999	25

Facility Name & ID Number

PARK HOUSE

0034991

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	Name of Lender	2		3	4	5	6		7	8	9	10						
		Related**					Purpose of Loan	Monthly Payment Required					Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO											Original	Balance			
	A. Directly Facility Related																	
	Long-Term																	
1	RELATED PARTY:2320 S.LAWNDALE LLC						\$	\$			\$	1						
2	NOMURA		X	MORTGAGE				2,612,690			239,089	2						
3												3						
4	CAREPLUS MANAGEMENT	X		CAPITAL IMPR LOAN				32,175			3,309	4						
5												5						
	Working Capital																	
6	CARE PLUS MGMT	X									20,231	6						
7												7						
8												8						
9	TOTAL Facility Related						\$ 0	\$ 2,644,865			\$ 262,629	9						
	B. Non-Facility Related*																	
10	IRS, IDR, ETC		X	LATE FEES							46	10						
11												11						
12												12						
13												13						
14	TOTAL Non-Facility Related						\$ 0	\$ 0			\$ 46	14						
15	TOTALS (line 9+line14)						\$ 0	\$ 2,644,865			\$ 262,675	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.	\$	82,000	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.)	\$	80,592	2
3. Under or (over) accrual (line 2 minus line 1).	\$	(1,408)	3
4. Real Estate Tax accrual used for 2006 report. (Detail and explain your calculation of this accrual on the lines below.)	\$	83,400	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.	\$	81,992	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2001	72,924	8
	2002	73,742	9
	2003	78,046	10
	2004	79,779	11
	2005	80,592	12

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

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.

NOTES:

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

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 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 PARK HOUSE COUNTY COOK

FACILITY IDPH LICENSE NUMBER 0034991

CONTACT PERSON REGARDING THIS REPORT BOB KAGDA

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

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 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>16-26-105-075-0000</u>	<u>NURSING HOME</u>	\$ <u>35,574.81</u>	\$ <u>35,574.81</u>
2. <u>16-26-105-079-0000</u>	<u>NURSING HOME</u>	\$ <u>22,472.71</u>	\$ <u>22,472.71</u>
3. <u>16-26-105-080-0000</u>	<u>NURSING HOME</u>	\$ <u>22,544.12</u>	\$ <u>22,544.12</u>
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>80,591.64</u>	\$ <u>80,591.64</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 PARK HOUSE

0034991

Report Period Beginning:

01/01/2006 Ending:

12/31/2006

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 26,849 B. General Construction Type: Exterior BRICK Frame _____ Number of Stories _____

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

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

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

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

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, 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	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1				\$	1
2					2
3	TOTALS			\$ 0	3

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

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	106	1989		\$ 1,209,350	\$ 38,397	39	\$ 38,397	\$	\$ 689,537	4
5										5
6										6
7	RELATED PARTY-TAG 18				902		902			7
8	RELATED PARTY-TAG 18 IMPRV				534		534			8
	Improvement Type**									
9	LEASEHOLD IMPROVEMENTS	1989		17,739	563	20	887	324	15,320	9
10	LEASEHOLD IMPROVEMENTS	1989		4,204	0	15	0		4,204	10
11	LEASEHOLD IMPROVEMENTS	1990		11,700	371	20	585	214	9,549	11
12	LEASEHOLD IMPROVEMENTS	1991		17,413	553	20	871	318	13,500	12
13	LEASEHOLD IMPROVEMENTS	1992		55,138	1,858	31.5	1,750	(108)	25,696	13
14	LEASEHOLD IMPROVEMENTS	1993		26,399	748	31.5	838	90	11,313	14
15	LEASEHOLD IMPROVEMENTS	1994		3,400	87	39	87		1,113	15
16	ROOF REPAIR	1995		1,500	38	39	38		439	16
17	ROOF-TOP HEAT/A/C	1996		10,000	256	39	256		2,785	17
18	CEILING TILE/DUMBWAITER REPAIR	1996		12,253	314	39	314		3,337	18
19										19
20	RE-ROOF	1996		80,861	2,073	39	2,073		21,419	20
21	FIXTURES/WINDOWS	1996		3,850	99	39	99		1,009	21
22	WINDOWS	1997		18,900	484	39	484		4,522	22
23	ROOF REPAIR & ROOF-TOP HEAT/A/C INSTALLATION	1997		3,228	83	39	83		786	23
24	DOOR & FLOORING	1997		2,922	75	39	75		716	24
25	ELEVATOR REPAIR	1997		3,125	80	39	80		750	25
26	WINDOWS	1998		12,600	323	39	323		2,827	26
27	TILE & FLOORING	1998		23,810	611	39	611		5,330	27
28	ELECTRICAL, PLUMBING AND ELEVATOR REPAIR	1998		31,238	801	39	801		6,917	28
29	NEW NURSE STATION	1998		24,271	622	39	622		5,521	29
30	WINDOW TREATMENTS AND BRAILLE SIGNS	1998		3,478	89	39	89		775	30
31	FIRE SYSTEM UPGRADE AND DAMPERS	1998		8,833	227	39	227		1,889	31
32	REAR PARKING LOT REPAIRS	1998		10,550	703	15	703		5,979	32
33	WINDOWS/CLOSETS/OUTLETS/DUMBWAITS/ROOF	1999		23,174	594	39	594		4,579	33
34	ROOF REPAIR	1999		18,365	471	39	471		3,552	34
35	FRONT RAMP REPAIR	2000		1,200	44	27.5	44		250	35
36	VINYL TILE/KITCHEN	2000		6,213	226	27.5	226		1,460	36

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

See Page 12A, Line 70 for total

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

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

Report Period Beginning:

01/01/2006 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	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	DUMBWAITER REPAIR	2001	\$ 3,264	\$ 119	27.5	\$ 119	\$	\$ 689	37
38	SIDEWALK/TUCKPOINTING	2001	5,500	367	15	367		2,018	38
39	KEYPAD ENTRY SYSTEM	2001	3,800	138	27.5	138		707	39
40	BOILER	2002	5,229	190	27.5	190		847	40
41	AC UNITS	2002	6,365	231	27.5	231		1,030	41
42	FLOORING	2002	2,328	85	27.5	85		379	42
43	FIRE PUMP REPAIR	2003	1,750	64	27.5	64		220	43
44	ELECTRICAL TO ROOFTOP UNIT	2003	1,951	71	27.5	71		246	44
45	PAINTING	2003	20,800	756	27.5	756		2,616	45
46	CEILING & DOOR REPAIR	2003	1,180	43	27.5	43		149	46
47	CONCRETE REPAIRS	2003	2,961	108	27.5	108		374	47
48	REBUILD NEW BATHROOMS	2004	7,478	272	27.5	272		669	48
49	WATER PUMP	2004	2,547	93	27.5	93		228	49
50	BOILER,BURNER,BACKSPLASH,GREASE TRAP/EXCAVATI	2005	8,945	325	27.5	325		478	50
51	WALL AC/CARPET	2005	14,131	514	27.5	514		751	51
52	ELEVATOR REPAIR/ ROOFTOP AC	2005	22,770	828	5	828		1,202	52
53	PAINTING	2006	13,760	2,752	15	2,752		2,752	53
54	LANDSCAPING & CEMENT WORK	2006	13,400	447	27.5	447		447	54
55	BATHROOM REMODEL	2006	3,800	63	27.5	63		63	55
56	EMERGENCY LIGHTS, ALARMS & LOCKS	2006	9,288	155		155		155	56
57									57
58									58
59	CARE PLUS REHAB:								59
60	WINDOWS	2004	11,385	292	39	292		669	60
61	FLOORING	2004	30,110	772	39	772		2,284	61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 1,838,456	\$ 60,911		\$ 61,749	\$ 838	\$ 864,047	70

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

Facility Name & ID Number **PARK HOUSE**

0034991

Report Period Beginning:

01/01/2006

Ending:

12/31/2006

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	\$ 169,492	\$ 11,357	\$ 15,945	\$ 4,588	10 YRS	\$ 104,777	71
72	Current Year Purchases	40,038	8,008	2,002	(6,006)	10 YRS	2,002	72
73	Fully Depreciated Assets	122,657			0		122,657	73
74	RELATED PARTY		5,524	5,524	0			74
75	TOTALS	\$ 332,187	\$ 24,889	\$ 23,471	\$ (1,418)		\$ 229,436	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)	\$ 2,170,643	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 85,800	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 85,220	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (580)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,093,483	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: NA
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? YES NO
If NO, see instructions.

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

8. List separately any amortization of lease expense included on page 4, line 34. _____
This amount was calculated by dividing the total amount to be amortized _____
by the length of the lease _____.

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

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

15. Is Movable equipment rental included in building rental? YES NO
16. Rental Amount for movable equipment: \$ 36,739 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	<u>MGMT CO ALLOC</u>		\$	\$ <u>2,578</u>	17
18					18
19					19
20					20
21	TOTAL		\$	\$ 2,578	21

10. Effective dates of current rental agreement:
Beginning _____
Ending _____

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

	Fiscal Year Ending	Annual Rent
12.	<u>/2007</u>	\$ _____
13.	<u>/2008</u>	\$ _____
14.	<u>/2009</u>	\$ _____

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

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

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility		3	4
		1	2		
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$ 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	\$		\$ 28,634	\$		\$ 28,634	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			837			837	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			56,012			56,012	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescripts				41,935		41,935	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			\$		\$ 85,483	\$ 41,935		\$ 127,418	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 **PARK HOUSE**# **0034991**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	\$ 4,910	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>82,170</u>)	1,128,215		3
4	Supply Inventory (priced at _____)			4
5	Short-Term Investments			5
6	Prepaid Insurance	14,556		6
7	Other Prepaid Expenses	15,764		7
8	Accounts Receivable (owners or related parties)	841,330		8
9	Other(specify): <u>RE TAX ESCROW</u>	33,857		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,038,632	\$ 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	427,864		15
16	Equipment, at Historical Cost	332,187		16
17	Accumulated Depreciation (book methods)	(373,576)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <u>REPL RESV</u>	135,613		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 522,088	\$ 0	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,560,720	\$ 0	25

		1	2	
		Operating	After	
			Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 519,129	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	108,796		30
31	Accrued Taxes Payable (excluding real estate taxes)	16,389		31
32	Accrued Real Estate Taxes(Sch.IX-B)	83,400		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)	\$ 727,714	\$ 0	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	55,797		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 55,797	\$ 0	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 783,511	\$ 0	46
47	TOTAL EQUITY (page 18, line 24)	\$ 1,777,209	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,560,720	\$ 0	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$	1
2	Restatements (describe):	2,293,003	2
3	POST CLOSING ADJUSTMENTS	(221,910)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 2,071,093	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(293,884)	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)	\$ (293,884)	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)	\$ 1,777,209	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	\$ 3,671,288	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,671,288	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	29,310	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 29,310	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***	52,180	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 52,180	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)	\$ 3,752,778	30

2

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	688,919	31
32	Health Care	1,339,264	32
33	General Administration	1,325,978	33
	B. Capital Expense		
34	Ownership	507,048	34
	C. Ancillary Expense		
35	Special Cost Centers	127,418	35
36	Provider Participation Fee	58,035	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 4,046,662	40
41	Income before Income Taxes (line 30 minus line 40)**	(293,884)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (293,884)	43

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

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

TAX RETURN PREPARED ON CASH BASIS

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

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

Facility Name & ID Number **PARK HOUSE**

0034991

Report Period Beginning: 01/01/2006

Ending: 12/31/2006

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	2,560	2,688	\$ 85,541	\$ 31.82	1
2	Assistant Director of Nursing	232	276	9,740	35.29	2
3	Registered Nurses	1,252	1,394	35,813	25.69	3
4	Licensed Practical Nurses	10,916	11,838	282,520	23.87	4
5	CNAs & Orderlies	41,947	46,240	443,410	9.59	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	2,834	3,012	26,168	8.69	8
9	Activity Director	2,769	2,876	22,598	7.86	9
10	Activity Assistants	3,809	4,267	40,168	9.41	10
11	Social Service Workers	10,080	11,214	168,402	15.02	11
12	Dietician					12
13	Food Service Supervisor	1,984	2,198	34,398	15.65	13
14	Head Cook	5,441	5,942	48,807	8.21	14
15	Cook Helpers/Assistants	8,453	9,318	74,946	8.04	15
16	Dishwashers					16
17	Maintenance Workers	2,048	2,087	26,188	12.55	17
18	Housekeepers	12,587	13,675	127,929	9.35	18
19	Laundry	3,977	4,258	34,574	8.12	19
20	Administrator	2,080	2,087	61,769	29.60	20
21	Assistant Administrator	119	119	2,500	21.01	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	10,127	11,159	154,201	13.82	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	1,903	2,053	18,736	9.13	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	125,118	136,701	\$ 1,698,408 *	\$ 12.42	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	\$ 6,554	1-3	35
36	Medical Director	O	14,600	9-3	36
37	Medical Records Consultant	N	1,080	10-3	37
38	Nurse Consultant	T	0	10-3	38
39	Pharmacist Consultant	H	900	10-3	39
40	Physical Therapy Consultant	L	5,400	10a-3	40
41	Occupational Therapy Consultant	Y	5,400	10a-3	41
42	Respiratory Therapy Consultant		0	10a-3	42
43	Speech Therapy Consultant	F	0	10a-3	43
44	Activity Consultant	E	3,754	11-3	44
45	Social Service Consultant	E	0	12-3	45
46	Other(specify)	S			46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 37,688		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

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	
RAFI ZIMMERMAN	ADMINISTRATOR		\$ 40,804	Workers' Compensation Insurance	\$ 62,706	IDPH License Fee	\$	
YECHIEL MASHIACH	ASST ADMIN		2,500	Unemployment Compensation Insurance	53,597	Advertising: Employee Recruitment	45,071	
EDUARDO TORRES	ADMINISTRATOR		20,965	FICA Taxes	129,510	Health Care Worker Background Check	194	
				Employee Health Insurance	46,575	(Indicate # of checks performed)		
				Employee Meals	0	Patient Background Checks	0	
				Illinois Municipal Retirement Fund (IMRF)*		TRUST/FRANCHISE/CONTRIB/ETC	300	
				EMPLOYEE BENEFITS - OTHER	19,128	MARKETING/ADV/PROMO	7,337	
				EMPLOYEE PHYSICAL EXAMS	0	LICENSES/DUES/SUBSCRIPTIONS	6,710	
				PENSION/PROFIT SHARING PLANS	0	MGMT CO ALLOC	1,517	
				CHICAGO HEAD TAX	2,860	TRUST/FRANCHISE/CONTRIB/ETC	(300)	
				INSURANCE - EXECUTIVE LIFE	0	Less: Public Relations Expense	(0)	
				INSURANCE - EXECUTIVE LIFE VI 21	0	Non-allowable advertising	(7,337)	
						Yellow page advertising	(0)	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 64,269	TOTAL (agree to Schedule V, line 22, col.8)	\$ 314,376	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 53,492	
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Description			Amount	Description	Line #	Amount	Description	Amount
CARE PLUS MANAGEMENT			\$ 219,600			\$	Out-of-State Travel	\$
HUNTER MANAGEMENT			84,000					
							In-State Travel	0
							MGMT CO ALLOC	664
							Seminar Expense	0
							Entertainment Expense	()
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 303,600	TOTAL		\$	TOTAL (agree to Sch. V, line 24, col. 8)	\$ 664
C. Professional Services								
Vendor/Payee	Type		Amount					
			\$					
SEE SCHEDULE ATTACHED			220,549					
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 220,549					

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number PARK HOUSE# 0034991Report Period Beginning: 01/01/2006Ending: 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? NO
If YES, give association name and amount. _____
- (3) Did the nursing home make political contributions or payments to a political action organization? YES If YES, have these costs been properly adjusted out of the cost report? YES
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? YES
What was the average life used for new equipment added during this period? 10 YR
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 0 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. \$ 58,035
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. \$ 0 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