

Facility Name & ID Number River Park Healthcare Center

0042549 Report Period Beginning: 01/01/07 Ending: 12/31/07

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>177</u>	Skilled (SNF)	<u>177</u>	<u>64,605</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>177</u>	TOTALS	<u>177</u>	<u>64,605</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		2 Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	<u>1,357</u>		<u>3,785</u>	<u>5,142</u>	8
9	SNF/PED					9
10	ICF	<u>41,109</u>	<u>3,264</u>	<u>358</u>	<u>44,731</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>42,466</u>	<u>3,264</u>	<u>4,143</u>	<u>49,873</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 77.20%

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

None (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.

(E.g., day care, "meals on wheels", outpatient therapy)

None

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

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?

YES NO

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES NO

I. On what date did you start providing long term care at this location?

Date started 03/06/1997

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

YES Date 03/06/1997 NO

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

YES NO If YES, enter number of beds certified 177 and days of care provided 3,785

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/2007 Fiscal Year: 12/31/2007

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

Facility Name & ID Number River Park Healthcare Center # 0042549 Report Period Beginning: 01/01/07 Ending: 12/31/07

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 BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	222,495	22,752	16,080	261,327		261,327	(4,121)	257,206		1
2	Food Purchase		235,056		235,056	(15,023)	220,033	(154)	219,879		2
3	Housekeeping	159,490	35,157		194,647		194,647	143	194,790		3
4	Laundry	68,607	19,738	11,635	99,980		99,980	(13)	99,967		4
5	Heat and Other Utilities			148,784	148,784		148,784	(9,914)	138,870		5
6	Maintenance	55,833	40,491	61,332	157,656		157,656	2,335	159,991		6
7	Other (specify):*							644	644		7
8	TOTAL General Services	506,425	353,194	237,831	1,097,450	(15,023)	1,082,427	(11,079)	1,071,348		8
	B. Health Care and Programs										
9	Medical Director			26,550	26,550		26,550		26,550		9
10	Nursing and Medical Records	1,661,885	144,592	13,284	1,819,761		1,819,761	22,344	1,842,105		10
10a	Therapy	177,440	5,834	15,320	198,594		198,594	11,577	210,171		10a
11	Activities	90,908	13,910		104,818		104,818		104,818		11
12	Social Services	23,856		5,035	28,891		28,891		28,891		12
13	CNA Training										13
14	Program Transportation			30	30		30		30		14
15	Other (specify):*							831	831		15
16	TOTAL Health Care and Programs	1,954,089	164,336	60,219	2,178,644		2,178,644	34,752	2,213,396		16
	C. General Administration										
17	Administrative	57,976		26,932	84,908		84,908	66,394	151,302		17
18	Directors Fees										18
19	Professional Services			263,164	263,164	(38)	263,126	(216,211)	46,915		19
20	Dues, Fees, Subscriptions & Promotions			36,015	36,015		36,015	(17,003)	19,012		20
21	Clerical & General Office Expenses	87,952	9,781	811,711	909,444		909,444	(604,521)	304,923		21
22	Employee Benefits & Payroll Taxes			358,440	358,440	15,023	373,463		373,463		22
23	Inservice Training & Education										23
24	Travel and Seminar			3,966	3,966		3,966	1,141	5,107		24
25	Other Admin. Staff Transportation			5,635	5,635		5,635	8,645	14,280		25
26	Insurance-Prop.Liab.Malpractice			168,667	168,667		168,667	1,651	170,318		26
27	Other (specify):*							54,310	54,310		27
28	TOTAL General Administration	145,928	9,781	1,674,530	1,830,239	14,985	1,845,224	(705,593)	1,139,631		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,606,442	527,311	1,972,580	5,106,333	(38)	5,106,295	(681,920)	4,424,375		29

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number River Park Healthcare Center #0042549 Report Period Beginning: 01/01/07 Ending: 12/31/07

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	D. Ownership										
30	Depreciation			23,306	23,306		23,306	113,107	136,413		30
31	Amortization of Pre-Op. & Org.										31
32	Interest			28,329	28,329		28,329	337,069	365,398		32
33	Real Estate Taxes			96,016	96,016	38	96,054	6,491	102,545		33
34	Rent-Facility & Grounds			472,058	472,058		472,058	(472,058)			34
35	Rent-Equipment & Vehicles			56,542	56,542		56,542	(45,368)	11,174		35
36	Other (specify):*							24,391	24,391		36
37	TOTAL Ownership			676,251	676,251	38	676,289	(36,367)	639,922		37
	Ancillary Expense										
	E. Special Cost Centers										
38	Medically Necessary Transportation										38
39	Ancillary Service Centers		114,316	220,231	334,547		334,547	12,436	346,983		39
40	Barber and Beauty Shops										40
41	Coffee and Gift Shops										41
42	Provider Participation Fee			96,908	96,908		96,908		96,908		42
43	Other (specify):*	29,686			29,686		29,686	(29,686)			43
44	TOTAL Special Cost Centers	29,686	114,316	317,139	461,141		461,141	(17,250)	443,891		44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,636,128	641,627	2,965,970	6,243,725		6,243,725	(735,537)	5,508,188		45

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number River Park Healthcare Center

0042549

Report Period Beginning: 01/01/07

Ending: 12/31/07

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	BHF 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	(10,745)	05		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(1,939)	30		9
10	Interest and Other Investment Income	(2,384)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(154)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(22,644)	21		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(418,303)	21		24
25	Fund Raising, Advertising and Promotional	(19,696)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(750)	21		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(48)	20		28
29	Other-Attach Schedule	(473,434)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (950,096)		\$	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)	214,559		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 214,559		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (735,537)		37

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

NON-ALLOWABLE EXPENSES	Amount	Sch. V Line	Reference
1 Theft and Damage	\$ (218)	21	1
2 Medicare Salary	(29,686)	41	2
3 Bank Charges	(103,913)	21	3
4 Non-Allowable Legal	(13,375)	19	4
5 Accounting Firm- Building Company	(7,500)	19	5
6 Amortization- Building Company	(3,218)	31	6
7 Bank Charges- Building Company	(180)	21	7
8 Prior Period Expenses	(16,875)	21	8
9 Non-Allowable Travel	(207)	25	9
10 Non-Allowable Rent Expense	(170,560)	35	10
11 Non-Allowable Expense	(126,500)	21	11
12			12
13			13
14			14
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17			17
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96			96
97			97
98			98
99			99
100			100
101 Total	(473,434)		101

STATE OF ILLINOIS

Summary A

Facility Name & ID Number River Park Healthcare Center

0042549

Report Period Beginning:

01/01/07

Ending:

12/31/07

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary					(4,121)							(4,121)	1
2	Food Purchase	(154)											(154)	2
3	Housekeeping			276				(133)					143	3
4	Laundry							(13)					(13)	4
5	Heat and Other Utilities	(10,745)		437	386				8				(9,914)	5
6	Maintenance			383	(2,966)		(47)		4,965				2,335	6
7	Other (specify):*				246	379	19						644	7
8	TOTAL General Services	(10,899)		1,096	(2,334)	(3,742)	(28)	(145)	4,973				(11,079)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records				(7,376)			(977)	30,697				22,344	10
10a	Therapy								3,760	7,817			11,577	10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*				831								831	15
16	TOTAL Health Care and Programs				(6,545)			(977)	34,457	7,817			34,752	16
	C. General Administration													
17	Administrative			6,518	(17,840)	14,436	(1,440)		64,720				66,394	17
18	Directors Fees													18
19	Professional Services	(20,875)	7,500	(37,762)	131	3,978	(4,780)		(164,403)				(216,211)	19
20	Fees, Subscriptions & Promotions	(19,744)		91	535				2,115				(17,003)	20
21	Clerical & General Office Expenses	(690,485)	180	21,563	870	65			63,286				(604,521)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar			9	71				1,061				1,141	24
25	Other Admin. Staff Transportation	(307)		322	931				7,699				8,645	25
26	Insurance-Prop.Liab.Malpractice			120	141	68			1,322				1,651	26
27	Other (specify):*			4,142	1,505	4,910			43,753				54,310	27
28	TOTAL General Administration	(731,411)	7,680	(4,997)	(13,656)	23,458	(6,220)		19,553				(705,593)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(742,310)	7,680	(3,901)	(22,535)	19,716	(6,248)	(1,122)	58,983	7,817			(681,920)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number River Park Healthcare Center

0042549

Report Period Beginning:

01/01/07

Ending:

12/31/07

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	(1,939)	94,106	549	1,132				9,302	9,957			113,107	30
31	Amortization of Pre-Op. & Org.	(3,218)	3,218											31
32	Interest	(2,384)	299,602	(21)	789				30,382	8,701			337,069	32
33	Real Estate Taxes			942	1,306				4,243				6,491	33
34	Rent-Facility & Grounds		(472,058)										(472,058)	34
35	Rent-Equipment & Vehicles	(170,560)	170,560	767	468	742			6,236	(53,581)			(45,368)	35
36	Other (specify):*		24,391										24,391	36
37	TOTAL Ownership	(178,101)	119,819	2,237	3,695	742			50,163	(34,923)			(36,367)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers									12,436			12,436	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(29,686)											(29,686)	43
44	TOTAL Special Cost Centers	(29,686)								12,436			(17,250)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(950,096)	127,499	(1,664)	(18,840)	20,458	(6,248)	(1,122)	109,146	(14,670)			(735,537)	45

Facility Name & ID Number River Park Healthcare Center

0042549

Report Period Beginning:

01/01/07

Ending:

12/31/07

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Attached		See Attached		See Attached		
				Rock Island HC Properties		Building Co.
				River Park Realty		Building Co.

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 Rental Income	\$ 202,560	Rock Island Healthcare Properties	100.00%	\$	\$ (202,560)	1
2	V	32 Interest Income	10	Rock Island Healthcare Properties	100.00%		(10)	2
3	V	35 Rent Expense		Rock Island Healthcare Properties	100.00%	170,560	170,560	3
4	V	32 Interest Expense		Rock Island Healthcare Properties	100.00%	29,841	29,841	4
5	V							5
6	V	34 Rental Income	269,498	River Park Realty	100.00%		(269,498)	6
7	V	32 Interest Income	2,278	River Park Realty	100.00%		(2,278)	7
8	V	19 Accounting Fees		River Park Realty	100.00%	7,500	7,500	8
9	V	31 Amortization- Loan Fees		River Park Realty	100.00%	3,218	3,218	9
10	V	21 Bank Charges		River Park Realty	100.00%	180	180	10
11	V	30 Depreciation		River Park Realty	100.00%	94,106	94,106	11
12	V	36 Insurance- MIP		River Park Realty	100.00%	24,391	24,391	12
13	V	32 Interest Expense		River Park Realty	100.00%	272,049	272,049	13
14	Total		\$ 474,346			\$ 601,845	\$ * 127,499	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number River Park Healthcare Center# 0042549Report Period Beginning: 01/01/07Ending: 12/31/07

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	3 HOUSEKEEPING	\$	PREFERRED BOOKKEEPING	100.00%	\$ 276	\$ 276	15
16	V	5 UTILITIES		PREFERRED BOOKKEEPING	100.00%	437	437	16
17	V	6 REPAIRS AND MAINT.		PREFERRED BOOKKEEPING	100.00%	383	383	17
18	V	17 ADMIN. FINANCIAL SAL.		PREFERRED BOOKKEEPING	100.00%	6,518	6,518	18
19	V	19 PROFESSIONAL FEES		PREFERRED BOOKKEEPING	100.00%	310	310	19
20	V	20 DUES,SUBSCRIPTIONS		PREFERRED BOOKKEEPING	100.00%	91	91	20
21	V	21 CLERICAL		PREFERRED BOOKKEEPING	100.00%	21,563	21,563	21
22	V	24 SEMINARS		PREFERRED BOOKKEEPING	100.00%	9	9	22
23	V	25 ADMIN. STAFF TRAVEL		PREFERRED BOOKKEEPING	100.00%	322	322	23
24	V	26 INSURANCE		PREFERRED BOOKKEEPING	100.00%	120	120	24
25	V	27 EMPLOYEE BENEFITS		PREFERRED BOOKKEEPING	100.00%	4,142	4,142	25
26	V	30 DEPRECIATION		PREFERRED BOOKKEEPING	100.00%	549	549	26
27	V	32 INTEREST		PREFERRED BOOKKEEPING	100.00%	(21)	(21)	27
28	V	33 REAL ESTATE TAXES		PREFERRED BOOKKEEPING	100.00%	942	942	28
29	V	35 EQUIPMENT RENTAL		PREFERRED BOOKKEEPING	100.00%	767	767	29
30	V							30
31	V							31
32	V	19 ACCOUNT./BOOKKEEPING	38,072	PREFERRED BOOKKEEPING	100.00%		(38,072)	32
33	V	19 COMPUTER	1,416	PREFERRED BOOKKEEPING	100.00%	1,416		33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$ 39,488			\$ 37,824	\$ * (1,664)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number River Park Healthcare Center# 0042549Report Period Beginning: 01/01/07Ending: 12/31/07

VII. RELATED PARTIES (continued)

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

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

1 Schedule V	2 Line	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
		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	\$	S.I.R. MANAGEMENT, INC.	100.00%	\$ 386	\$ 386	15
16	V	6 REPAIRS AND MAINT.	5,308	S.I.R. MANAGEMENT, INC.	100.00%	2,342	(2,966)	16
17	V	7 EMP. BEN.-GEN. SERV.		S.I.R. MANAGEMENT, INC.	100.00%	246	246	17
18	V	10 NURSING	11,684	S.I.R. MANAGEMENT, INC.	100.00%	4,308	(7,376)	18
19	V	15 EMP. BEN.-H.C.		S.I.R. MANAGEMENT, INC.	100.00%	831	831	19
20	V	17 ADMINISTRATIVE	20,712	S.I.R. MANAGEMENT, INC.	100.00%	2,872	(17,840)	20
21	V	19 PROFESSIONAL FEES		S.I.R. MANAGEMENT, INC.	100.00%	131	131	21
22	V	20 FEES,SUBSCRIPTIONS		S.I.R. MANAGEMENT, INC.	100.00%	535	535	22
23	V	21 CLERICAL & GENERAL	6,016	S.I.R. MANAGEMENT, INC.	100.00%	6,886	870	23
24	V	24 EDUCATION & SEMINAR		S.I.R. MANAGEMENT, INC.	100.00%	71	71	24
25	V	25 OTHER ADMIN. STAFF TRANS.		S.I.R. MANAGEMENT, INC.	100.00%	931	931	25
26	V	26 INSURANCE		S.I.R. MANAGEMENT, INC.	100.00%	141	141	26
27	V	27 EMP. BEN.-GEN. ADMIN.		S.I.R. MANAGEMENT, INC.	100.00%	1,505	1,505	27
28	V	30 DEPRECIATION		S.I.R. MANAGEMENT, INC.	100.00%	1,132	1,132	28
29	V	32 INTEREST		S.I.R. MANAGEMENT, INC.	100.00%	789	789	29
30	V	33 REAL ESTATE TAXES		S.I.R. MANAGEMENT, INC.	100.00%	1,306	1,306	30
31	V	35 EQUIPMENT RENTAL		S.I.R. MANAGEMENT, INC.	100.00%	468	468	31
32	V							32
33	V	39 LEASED EQUIPMENT		S.I.R. MANAGEMENT, INC.	100.00%			33
34	V	30 DEPRECIATION		S.I.R. MANAGEMENT, INC.	100.00%			34
35	V	32 INTEREST		S.I.R. MANAGEMENT, INC.	100.00%			35
36	V							36
37	V							37
38	V							38
39	Total		\$ 43,720			\$ 24,880	\$ * (18,840)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number River Park Healthcare Center# 0042549Report Period Beginning: 01/01/07Ending: 12/31/07

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	1	DIETARY SALARIES	\$ 6,016	S.I.R. MANAGEMENT, INC.	100.00%	\$ 1,895	\$ (4,121)	15
16	V	7	EMP. BEN.-DIETARY		S.I.R. MANAGEMENT, INC.	100.00%	379	379	16
17	V	17	ADMIN./LEGAL SALARIES		S.I.R. MANAGEMENT, INC.	100.00%	13,216	13,216	17
18	V	19	FINANCIAL CONSULTANT		S.I.R. MANAGEMENT, INC.	100.00%	3,978	3,978	18
19	V	27	EMP. BEN.-ADMINISTRATIVE		S.I.R. MANAGEMENT, INC.	100.00%	2,664	2,664	19
20	V								20
21	V	17	ADMIN. SALARY-B. BARRISH		S.I.R. MANAGEMENT, INC.	100.00%	848	848	21
22	V	6	REPAIRS & MAINT.-B. BARRISH		S.I.R. MANAGEMENT, INC.	100.00%			22
23	V	21	CLERICAL & GEN.-B. BARRISH		S.I.R. MANAGEMENT, INC.	100.00%	49	49	23
24	V	26	AUTO INSURANCE-B. BARRISH		S.I.R. MANAGEMENT, INC.	100.00%	31	31	24
25	V	27	EMP. BENEFITS-B. BARRISH		S.I.R. MANAGEMENT, INC.	100.00%	1,135	1,135	25
26	V	35	AUTO LEASE-B. BARRISH		S.I.R. MANAGEMENT, INC.	100.00%	430	430	26
27	V								27
28	V	17	ADMIN. SALARY-M. GIANNINI		S.I.R. MANAGEMENT, INC.	100.00%	372	372	28
29	V	21	CLERICAL & GEN.-M. GIANNINI		S.I.R. MANAGEMENT, INC.	100.00%	16	16	29
30	V	26	AUTO INSURANCE-M. GIANNINI		S.I.R. MANAGEMENT, INC.	100.00%	37	37	30
31	V	27	EMP. BENEFITS-M. GIANNINI		S.I.R. MANAGEMENT, INC.	100.00%	1,111	1,111	31
32	V	35	AUTO LEASE-M. GIANNINI		S.I.R. MANAGEMENT, INC.	100.00%	312	312	32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total		\$ 6,016				\$ 26,474	\$ * 20,458	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	10A SPECIAL REHAB		S.I.R. MANAGEMENT, INC.	100.00%		\$	15	
16	V	15 EMP. BEN.-H. CARE & PROG.		S.I.R. MANAGEMENT, INC.	100.00%			16	
17	V							17	
18	V	6 REPAIRS AND MAINT.	144	S.I.R. MANAGEMENT, INC.	100.00%	97	(47)	18	
19	V	7 EMP. BEN.-GEN. SERV.		S.I.R. MANAGEMENT, INC.	100.00%	19	19	19	
20	V							20	
21	V							21	
22	V							22	
23	V							23	
24	V							24	
25	V	19 LEGAL FEES	4,780	S.I.R. MANAGEMENT, INC.	100.00%		(4,780)	25	
26	V							26	
27	V	17 COUNCIL DUES	1,440	S.I.R. MANAGEMENT, INC.	100.00%		(1,440)	27	
28	V							28	
29	V							29	
30	V							30	
31	V							31	
32	V							32	
33	V							33	
34	V							34	
35	V							35	
36	V							36	
37	V							37	
38	V							38	
39	Total		\$ 6,364			\$ 116	\$ *	(6,248)	39

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	1 Dietary	\$	Xcel Supply, LLC	100.00%	\$		15
16	V	3 Housekeeping	1,646	Xcel Supply, LLC	100.00%	1,513	(133)	16
17	V	4 Laundry	156	Xcel Supply, LLC	100.00%	143	(13)	17
18	V	6 Repairs & Maintenance		Xcel Supply, LLC	100.00%			18
19	V	10 Nursing	12,109	Xcel Supply, LLC	100.00%	11,132	(977)	19
20	V	11 Activities		Xcel Supply, LLC	100.00%			20
21	V	12 Social Service		Xcel Supply, LLC	100.00%			21
22	V	20 Dues, Fees And Subscriptions		Xcel Supply, LLC	100.00%			22
23	V	21 Office And Clerical		Xcel Supply, LLC	100.00%			23
24	V	22 Employee Benefits		Xcel Supply, LLC	100.00%			24
25	V	24 Seminars & Education		Xcel Supply, LLC	100.00%			25
26	V	39 Ancillary		Xcel Supply, LLC	100.00%			26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$ 13,911			\$ 12,789	\$ * (1,122)	39

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

Facility Name & ID Number River Park Healthcare Center# 0042549Report Period Beginning: 01/01/07Ending: 12/31/07

VII. RELATED PARTIES (continued)

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

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

1 Schedule V	2 Line	3 Cost Per General Ledger		4 Amount	5 Cost to Related Organization		6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item			Name of Related Organization					
15	V	05	Utilities	\$	Careplus Management, INC	100.00%	\$ 8	\$ 8	15	
16	V	06	Repairs		Careplus Management, INC	100.00%	884	884	16	
17	V	06	Maintenance Salary		Careplus Management, INC	100.00%	4,040	4,040	17	
18	V	06	Security		Careplus Management, INC	100.00%	41	41	18	
19	V	10	Nursing		Careplus Management, INC	100.00%	30,697	30,697	19	
20	V	10a	Therapy Salaries		Careplus Management, INC	100.00%	2,857	2,857	20	
21	V	10a	Therapy Supplies		Careplus Management, INC	100.00%	903	903	21	
22	V	17	Administrative Salaries		Careplus Management, INC	100.00%	64,720	64,720	22	
23	V	19	Professional Fees		Careplus Management, INC	100.00%	5,257	5,257	23	
24	V	20	Dues/Licenses/Want Ads		Careplus Management, INC	100.00%	2,115	2,115	24	
25	V	21	Office Expense		Careplus Management, INC	100.00%	16,183	16,183	25	
26	V	21	Clerical Salaries		Careplus Management, INC	100.00%	47,103	47,103	26	
27	V	24	Seminars		Careplus Management, INC	100.00%	1,061	1,061	27	
28	V	25	Travel		Careplus Management, INC	100.00%	1,570	1,570	28	
29	V	25	Transportation		Careplus Management, INC	100.00%	6,129	6,129	29	
30	V	26	Insurance		Careplus Management, INC	100.00%	1,322	1,322	30	
31	V	27	Employee Benefits		Careplus Management, INC	100.00%	43,753	43,753	31	
32	V	30	Depreciation		Careplus Management, INC	100.00%	9,302	9,302	32	
33	V	32	Interest		Careplus Management, INC	100.00%	30,382	30,382	33	
34	V	33	Real Estate Tax		Careplus Management, INC	100.00%	4,243	4,243	34	
35	V	35	Equipment Rental/Auto Lease		Careplus Management, INC	100.00%	6,236	6,236	35	
36	V								36	
37	V	19	Professional Fees	169,660	Careplus Management, INC	100.00%		(169,660)	37	
38	V								38	
39	Total			\$ 169,660			\$ 278,806	\$ * 109,146	39	

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

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

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	10a	Therapy Services	\$ 65,368	Careplus Rehabilitative Services	100.00%	\$ 72,229	\$ 6,861	15
16	V	39	Ancillary Therapy	86,147	Careplus Rehabilitative Services	100.00%	95,188	9,041	16
17	V	35	Equipment Rent Expense	53,581	Careplus Rehabilitative Services	100.00%		(53,581)	17
18	V	30	Depreciation		Careplus Rehabilitative Services	100.00%	9,957	9,957	18
19	V	32	Interest		Careplus Rehabilitative Services	100.00%	8,701	8,701	19
20	V	10a	Therapy Services	9,108	Careplus Rehabilitative Services	100.00%	10,064	956	20
21	V	39	Ancillary Therapy	32,346	Careplus Rehabilitative Services	100.00%	35,741	3,395	21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total		\$ 246,550				\$ 231,880	\$ * (14,670)	39

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

Facility Name & ID Number River Park Healthcare Center

0042549

Report Period Beginning: 01/01/07

Ending: 12/31/07

VII. RELATED PARTIES (continued)

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number River Park Healthcare Center

0042549

Report Period Beginning: 01/01/07

Ending: 12/31/07

VII. RELATED PARTIES (continued)

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number River Park Healthcare Center # 0042549 Report Period Beginning: 01/01/07 Ending: 12/31/07

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	Mike Giannini	See Attached	Administrative		See Attached	1.15	2.88%	Alloc. Salary	\$ 372	17-7	1
2	Eric Rothner	See Attached	Administrative		See Attached	0.19	0.41%	Alloc. Salary	2,573	17-7	2
3	Ronald Nunziatio	See Attached	Clerical		See Attached	1.06	2.65%	Alloc. Salary	2,546	21-7	3
4	Bryan Barrish	See Attached	Administrative		See Attached	0.89	2.23%	Alloc. Salary	848	17-7	4
5	Nenita Guzman	See Attached	Dietary		See Attached	1.33	2.66%	Alloc. Salary	1,895	1-7	5
6	Patricia McDiarmid	See Attached	Administrative		See Attached	1.33	2.66%	Alloc. Salary	2,872	17-7	6
7	Louise Bergthold	See Attached	Administrative		See Attached	1.46	2.65%	Alloc. Salary	4,774	17-7	7
8	Tom Winter	See Attached	Administrative		See Attached	2.17	3.62%	Alloc. Salary	6,518	17-7	8
9	Jeff Oravec	See Attached	Administrative		See Attached	1.06	2.65%	Al. Sal/Fees	3,349	17-7	9
10	Jakob Bakst	See Attached	Administrative		See Attached	4.50	7.50%	Alloc. Salary	12,458	17-7	10
11	Sherwin Ray	See Attached	Administrative		See Attached	4.50	7.50%	Alloc. Salary	12,458	17-7	11
12	Roslyn Indich	See Attached	Administrative		See Attached	4.50	7.50%	Alloc. Salary	3,732	17-7	12
13								TOTAL	\$ 54,395		13

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number River Park Healthcare Center

0042549

Report Period Beginning: 01/01/07

Ending: 12/31/07

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number River Park Healthcare Center

0042549

Report Period Beginning: 01/01/07

Ending: 12/31/07

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 PREFERRED BOOKKEEPING SERVICES
 Street Address 4100 WEST PRATT AVE.
 City / State / Zip Code LINCOLNWOOD, IL. 60712
 Phone Number (847) 674-5200
 Fax Number (847) 674-5267

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	3	HOUSEKEEPING	BOOK./ACCNT.INCOME 1,051,322	10	\$ 7,611	\$	38,072	\$ 276	1
2	5	UTILITIES	BOOK./ACCNT.INCOME 1,051,322	10	12,056		38,072	437	2
3	6	REPAIRS AND MAINT.	BOOK./ACCNT.INCOME 1,051,322	10	10,582		38,072	383	3
4	17	ADMIN. FINANCIAL SAL.	BOOK./ACCNT.INCOME 1,051,322	10	180,000	180,000	38,072	6,518	4
5	19	PROFESSIONAL FEES	BOOK./ACCNT.INCOME 1,051,322	10	8,570		38,072	310	5
6	20	DUES,SUBSCRIPTIONS	BOOK./ACCNT.INCOME 1,051,322	10	2,521		38,072	91	6
7	21	CLERICAL	BOOK./ACCNT.INCOME 1,051,322	10	595,432	519,081	38,072	21,563	7
8	24	SEMINARS	BOOK./ACCNT.INCOME 1,051,322	10	240		38,072	9	8
9	25	ADMIN. STAFF TRAVEL	BOOK./ACCNT.INCOME 1,051,322	10	8,887		38,072	322	9
10	26	INSURANCE	BOOK./ACCNT.INCOME 1,051,322	10	3,314		38,072	120	10
11	27	EMPLOYEE BENEFITS	BOOK./ACCNT.INCOME 1,051,322	10	114,384		38,072	4,142	11
12	30	DEPRECIATION	BOOK./ACCNT.INCOME 1,051,322	10	15,147		38,072	549	12
13	32	INTEREST	BOOK./ACCNT.INCOME 1,051,322	10	(585)		38,072	(21)	13
14	33	REAL ESTATE TAXES	BOOK./ACCNT.INCOME 1,051,322	10	26,015		38,072	942	14
15	35	EQUIPMENT RENTAL	BOOK./ACCNT.INCOME 1,051,322	10	21,168		38,072	767	15
16									16
17									17
18									18
19	19	COMPUTER	DIRECT ALLOCATION					1,416	19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 1,005,342	\$ 699,081		\$ 37,824	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number River Park Healthcare Center

0042549

Report Period Beginning: 01/01/07

Ending: 12/31/07

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization S.I.R. MANAGEMENT, INC.
 Street Address 6840 N. LINCOLN
 City / State / Zip Code LINCOLNWOOD, IL. 60712
 Phone Number (847) 675 -7979
 Fax Number (847) 675 -0555

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	611,427	10	\$ 14,547	\$ 16,217	\$ 386	1	
2	6	REPAIRS AND MAINT.	PATIENT DAYS	611,427	10	88,312	52,015	16,217	2,342	2
3	7	EMP. BEN.-GEN. SERV.	PATIENT DAYS	611,427	10	9,289	16,217	16,217	246	3
4	10	NURSING	PATIENT DAYS	611,427	10	162,421	162,421	16,217	4,308	4
5	15	EMP. BEN.-H.C.	PATIENT DAYS	611,427	10	31,333	16,217	16,217	831	5
6	17	ADMINISTRATIVE	PATIENT DAYS	611,427	10	108,301	108,301	16,217	2,872	6
7	19	PROFESSIONAL FEES	PATIENT DAYS	611,427	10	4,925	16,217	16,217	131	7
8	20	FEES,SUBSCRIPTIONS	PATIENT DAYS	611,427	10	20,178	16,217	16,217	535	8
9	21	CLERICAL & GENERAL	PATIENT DAYS/DIRECT	611,427	10	259,625	203,511	16,217	6,886	9
10	24	EDUCATION & SEMINAR	PATIENT DAYS	611,427	10	2,693	16,217	16,217	71	10
11	25	OTHER ADMIN. STAFF TRANS	PATIENT DAYS	611,427	10	35,101	16,217	16,217	931	11
12	26	INSURANCE	PATIENT DAYS	611,427	10	5,328	16,217	16,217	141	12
13	27	EMP. BEN.-GEN. ADMIN.	PATIENT DAYS/DIRECT	611,427	10	56,748	16,217	16,217	1,505	13
14	30	DEPRECIATION	PATIENT DAYS	611,427	10	42,694	16,217	16,217	1,132	14
15	32	INTEREST	PATIENT DAYS	611,427	10	29,739	16,217	16,217	789	15
16	33	REAL ESTATE TAXES	PATIENT DAYS	611,427	10	49,229	16,217	16,217	1,306	16
17	35	EQUIPMENT RENTAL	PATIENT DAYS	611,427	10	17,659	16,217	16,217	468	17
18										18
19	39	LEASED EQUIPMENT	LEASING INCOME	28,470	1					19
20	30	DEPRECIATION	LEASING INCOME	28,470	1	8,367				20
21	32	INTEREST	LEASING INCOME	28,470	1	1,205				21
22										22
23										23
24										24
25	TOTALS					\$ 947,694	\$ 526,247		\$ 24,880	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number River Park Healthcare Center

0042549

Report Period Beginning: 01/01/07

Ending: 12/31/07

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization S.I.R. MANAGEMENT, INC.
 Street Address 6840 N. LINCOLN
 City / State / Zip Code LINCOLNWOOD, IL. 60712
 Phone Number (847) 675 -7979
 Fax Number (847) 675 -0555

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	1	DIETARY SALARIES	PATIENT DAYS	611,427	10	\$ 71,444	\$ 71,444	16,217	\$ 1,895	1
2	7	EMP. BEN.-DIETARY	PATIENT DAYS	611,427	10	14,275		16,217	379	2
3	17	ADMIN./LEGAL SALARIES	PATIENT DAYS	611,427	10	498,282	498,282	16,217	13,216	3
4	19	FINANCIAL CONSULTANT	PATIENT DAYS	611,427	10	149,980		16,217	3,978	4
5	27	EMP. BEN.-ADMINISTRATIVE	PATIENT DAYS	611,427	10	100,448		16,217	2,664	5
6										6
7	17	ADMIN. SALARY-B. BARRISH	AVG HRS WKD	23	10	22,231	22,231	1	848	7
8	6	REPAIRS & MAINT.-B. BARRIS	AVG HRS WKD	23	10			1		8
9	21	CLERICAL & GEN.-B. BARRIS	AVG HRS WKD	23	10	1,275		1	49	9
10	26	AUTO INSURANCE-B. BARRIS	AVG HRS WKD	23	10	824		1	31	10
11	27	EMP. BENEFITS-B. BARRISH	AVG HRS WKD	23	10	29,750		1	1,135	11
12	35	AUTO LEASE-B. BARRISH	AVG HRS WKD	23	10	11,272		1	430	12
13										13
14	17	ADMIN. SALARY-M. GIANNINI	AVG HRS WKD	30	10	9,702	9,702	1	372	14
15	21	CLERICAL & GEN.-M. GIANNI	AVG HRS WKD	30	10	425		1	16	15
16	26	AUTO INSURANCE-M. GIANNI	AVG HRS WKD	30	10	959		1	37	16
17	27	EMP. BENEFITS-M. GIANNINI	AVG HRS WKD	30	10	28,968		1	1,111	17
18	35	AUTO LEASE-M. GIANNINI	AVG HRS WKD	30	10	8,144		1	312	18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 947,979	\$ 601,659		\$ 26,474	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number River Park Healthcare Center

0042549

Report Period Beginning: 01/01/07

Ending: 12/31/07

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization S.I.R. MANAGEMENT, INC.
 Street Address 6840 N. LINCOLN
 City / State / Zip Code LINCOLNWOOD, IL. 60712
 Phone Number (847) 675 -7979
 Fax Number (847) 675 -0555

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	10A	SPECIAL REHAB	SPECIAL REHAB INC.	107,736	7	\$ 42,868	\$ 42,868		1
2	15	EMP. BEN.-H. CARE & PROG.	SPECIAL REHAB INC.	107,736	7	8,566			2
3									3
4	6	REPAIRS AND MAINT.	MAINTENANCE INC.	116,640	8	78,758	144	97	4
5	7	EMP. BEN.-GEN. SERV.	MAINTENANCE INC.	116,640	8	15,737	144	19	5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 145,929	\$ 121,626	\$ 116	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number River Park Healthcare Center

0042549

Report Period Beginning: 01/01/07

Ending: 12/31/07

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization Xcel Supply, LLC
 Street Address 2201 Main Street
 City / State / Zip Code Evanston, IL 60202
 Phone Number (847)328-7600
 Fax Number (847)328-7615

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	1	Dietary	Direct Allocation		\$	\$		\$	1
2	3	Housekeeping	Direct Allocation					1,513	2
3	4	Laundry	Direct Allocation					143	3
4	6	Repairs & Maintenance	Direct Allocation						4
5	10	Nursing	Direct Allocation					11,132	5
6	11	Activities	Direct Allocation						6
7	12	Social Service	Direct Allocation						7
8	20	Dues, Fees And Subscriptions	Direct Allocation						8
9	21	Office And Clerical	Direct Allocation						9
10	22	Employee Benefits	Direct Allocation						10
11	24	Seminars & Education	Direct Allocation						11
12	39	Ancillary	Direct Allocation						12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$ 12,789	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number River Park Healthcare Center

0042549

Report Period Beginning: 01/01/07

Ending: 12/31/07

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 Boulevard
 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	05	Utilities	Census Days	445,767	11 Facilities	\$ 100	\$ 33,656	\$ 8	1
2	06	Repairs	Census Days	445,767	11 Facilities	11,715	33,656	884	2
3	06	Maintenance Salary	Census Days	445,767	11 Facilities	53,507	53,507	4,040	3
4	06	Security	Census Days	445,767	11 Facilities	548	33,656	41	4
5	10	Nursing	Census Days	445,767	11 Facilities	406,577	406,577	30,697	5
6	10a	Therapy Salaries	Census Days	445,767	11 Facilities	37,834	33,656	2,857	6
7	10a	Therapy Supplies	Census Days	445,767	11 Facilities	11,963	33,656	903	7
8	17	Administrative Salaries	Census Days	445,767	11 Facilities	857,197	33,656	64,720	8
9	19	Professional Fees	Census Days	445,767	11 Facilities	69,630	33,656	5,257	9
10	20	Dues/Licenses/Want Ads	Census Days	445,767	11 Facilities	28,013	33,656	2,115	10
11	21	Office Expense	Census Days	445,767	11 Facilities	214,347	33,656	16,183	11
12	21	Clerical Salaries	Census Days	445,767	11 Facilities	623,871	623,871	47,103	12
13	24	Seminars	Census Days	445,767	11 Facilities	14,052	33,656	1,061	13
14	25	Travel	Census Days	445,767	11 Facilities	20,788	33,656	1,570	14
15	25	Transportation	Census Days	445,767	11 Facilities	81,177	33,656	6,129	15
16	26	Insurance	Census Days	445,767	11 Facilities	17,511	33,656	1,322	16
17	27	Employee Benefits	Census Days	445,767	11 Facilities	579,494	33,656	43,753	17
18	30	Depreciation	Census Days	445,767	11 Facilities	123,201	33,656	9,302	18
19	32	Interest	Census Days	445,767	11 Facilities	402,408	33,656	30,382	19
20	33	Real Estate Tax	Census Days	445,767	11 Facilities	56,199	33,656	4,243	20
21	35	Equipment Rental/Auto Lease	Census Days	445,767	11 Facilities	82,599	33,656	6,236	21
22									22
23									23
24									24
25	TOTALS					\$ 3,692,731	\$ 1,121,789	\$ 278,806	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number River Park Healthcare Center

0042549

Report Period Beginning: 01/01/07

Ending: 12/31/07

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 Rehabilitative Services
 Street Address 8320 Skokie Boulevard
 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	10a	Therapy Services	Direct		\$	\$		72,229	1
2	39	Ancillary Therapy	Direct					95,188	2
3	35	Equipment Rent Expense	Direct						3
4	30	Depreciation	Direct					9,957	4
5	32	Interest	Direct					8,701	5
6	10a	Therapy Services	Direct					10,064	6
7	39	Ancillary Therapy	Direct					35,741	7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		231,880	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number River Park Healthcare Center

0042549

Report Period Beginning: 01/01/07

Ending: 12/31/07

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number River Park Healthcare Center

0042549

Report Period Beginning: 01/01/07

Ending: 12/31/07

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	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	Cambridge/Heartland		X	Mortgage	\$29,195.15	11/2003	\$ 5,141,900	\$ 4,840,498	10/2033		\$ 301,067	1								
2												2								
3												3								
4												4								
5	See Supplemental Schedule											5								
Working Capital																				
6	SIR Management		X	Line of Credit	Demand			775,000		Prime +	7,364	6								
7	Careplus Management		X	Line of Credit	Demand					Prime +	20,965	7								
8	See Supplemental Schedule							1,801			40,674	8								
9	TOTAL Facility Related				\$29,195.15		\$ 5,141,900	\$ 5,617,299			\$ 370,070	9								
B. Non-Facility Related*																				
10	Interest Income		X								(2,384)	10								
11	Interest Income- Bldg Co.		X								(2,288)	11								
12												12								
13	See Supplemental Schedule											13								
14	TOTAL Non-Facility Related						\$	\$			(4,672)	14								
15	TOTALS (line 9+line14)						\$ 5,141,900	\$ 5,617,299			\$ 365,398	15								

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 24,391 Line # 36

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

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

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

1	2	3	4	5	6	7	8	9	10											
										Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
											YES	NO				Original	Balance			
A. Directly Facility Related																				
Long-Term																				
1																				
2																				
3																				
4																				
5																				
6																				
7	TOTAL Long-Term																			
Working Capital																				
8	Allocate From Preferred		X							(21)										
9	Allocate From SIR		X							789										
10	Allocate From Bldg Co.		X	Capital Improvement Loan			1,801			823										
11	Allocate From Careplus Mgt.		X							30,382										
12	Allocate From Careplus Rehab.		X							8,701										
13																				
14	TOTAL Working Capital									1,801	40,674									
B. Non-Facility Related*																				
15																				
16																				
17																				
18																				
19																				
20	TOTAL Non-Facility Related																			

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

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

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2006 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 2006 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2006.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2006 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 2007 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.

2006 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME River Park Healthcare Center COUNTY Rock Island

FACILITY IDPH LICENSE NUMBER 0042549

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

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

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2006 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 2006.

	(A)	(B)	(C)	(D) Tax Applicable to Nursing Home
	<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1.	<u>10-341-78-00</u>	<u>Long Term Care Property</u>	<u>\$ 135,207.68</u>	<u>\$ 135,207.68</u>
2.	<u>10-341-79-00</u>	<u>Long Term Care Property</u>	<u>\$ 1,328.00</u>	<u>\$ 1,328.00</u>
3.	<u>See Attached</u>	<u>Related Party Allocation</u>	<u>\$ 66,791.67</u>	<u>\$ 1,995.30</u>
4.	<u>See Attached</u>	<u>Related Party Allocation</u>	<u>\$ 59,366.51</u>	<u>\$ 4,243.00</u>
5.	<u>_____</u>	<u>_____</u>	<u>\$ _____</u>	<u>\$ _____</u>
6.	<u>_____</u>	<u>_____</u>	<u>\$ _____</u>	<u>\$ _____</u>
7.	<u>_____</u>	<u>_____</u>	<u>\$ _____</u>	<u>\$ _____</u>
8.	<u>_____</u>	<u>_____</u>	<u>\$ _____</u>	<u>\$ _____</u>
9.	<u>_____</u>	<u>_____</u>	<u>\$ _____</u>	<u>\$ _____</u>
10.	<u>_____</u>	<u>_____</u>	<u>\$ _____</u>	<u>\$ _____</u>
		TOTALS	<u>\$ 262,693.86</u>	<u>\$ 142,773.98</u>

B. Real Estate Tax Cost Allocations

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

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

C. Tax Bills

Attach a copy of the original 2006 tax bills which were listed in Section A to this statement. Be sure to use the 2006 tax bill which is normally paid during 2007.

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.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 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 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 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 Office of Health Finance at (217) 782-1630.

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME River Park Healthcare Center COUNTY Rock Island

FACILITY IDPH LICENSE NUMBER 0042549

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

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

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2000 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 2000.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. _____	_____	\$ _____	\$ _____
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ _____	\$ _____

B. Real Estate Tax Cost Allocations

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

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

C. Tax Bills

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

Facility Name & ID Number River Park Healthcare Center

0042549 Report Period Beginning:

01/01/07 Ending:

12/31/07

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 59,494 B. General Construction Type: Exterior Brick Frame Wood Number of Stories 4+ Basement

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

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

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

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

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

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	<u>Facility</u>	<u>5.16 Acres</u>	<u>1997</u>	<u>\$ 420,000</u>	1
2					2
3	TOTALS	5.16 Acres		\$ 420,000	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number River Park Healthcare Center

0042549

Report Period Beginning:

01/01/07

Ending:

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XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			2002	10,887		20	396	396	2,007	9
10	Various			2003	5,954		20	216	216	885	10
11											11
12											12
13											13
14											14
15											15
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26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

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

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

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number River Park Healthcare Center

0042549

Report Period Beginning:

01/01/07

Ending:

12/31/07

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
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63								63
64								64
65								65
66								66
67		3,668,696	94,107		95,830	1,723	970,405	67
68		174,023	20,251		8,378	(11,873)	19,364	68
69			19,999			(19,999)		69
70		\$ 3,859,560	\$ 134,357		\$ 104,820	\$ (29,537)	\$ 992,661	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number River Park Healthcare Center

0042549

Report Period Beginning:

01/01/07

Ending:

12/31/07

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 3,859,560	\$ 134,357		\$ 104,820	\$ (29,537)	\$ 992,661	1
2	Kickboards	2004	9,240		20	336	336	1,190	2
3	Security System /Exhaust Vents	2005	36,703		20	1,335	1,335	3,251	3
4	Gazebo/Fence	2005	12,057		20	804	804	2,009	4
5	Roof/Ac Compressor/Linen Chute Discharge Door	2006	12,843		20	467	467	915	5
6	Elevator Fire Service/Door Keypads	2006	26,225		20	954	954	1,602	6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,956,628	\$ 134,357		\$ 108,716	\$ (25,641)	\$ 1,001,628	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number River Park Healthcare Center

0042549

Report Period Beginning:

01/01/07

Ending:

12/31/07

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 3,956,628	\$ 134,357		\$ 108,716	\$ (25,641)	\$ 1,001,628	1
2									2
3									3
4									4
5									5
6									6
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8									8
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30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,956,628	\$ 134,357		\$ 108,716	\$ (25,641)	\$ 1,001,628	34

SEE ACCOUNTANTS' COMPILATION REPORT

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Facility Name & ID Number River Park Healthcare Center

0042549

Report Period Beginning:

01/01/07

Ending:

12/31/07

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 3,956,628	\$ 134,357		\$ 108,716	\$ (25,641)	\$ 1,001,628	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,956,628	\$ 134,357		\$ 108,716	\$ (25,641)	\$ 1,001,628	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number River Park Healthcare Center

0042549

Report Period Beginning:

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Ending:

12/31/07

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		\$ 3,956,628	\$ 134,357		\$ 108,716	\$ (25,641)	\$ 1,001,628	1
2									2
3									3
4									4
5									5
6									6
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27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,956,628	\$ 134,357		\$ 108,716	\$ (25,641)	\$ 1,001,628	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number River Park Healthcare Center

0042549

Report Period Beginning:

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Ending:

12/31/07

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12E, Carried Forward		\$ 3,956,628	\$ 134,357		\$ 108,716	\$ (25,641)	\$ 1,001,628	1
2									2
3									3
4									4
5									5
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31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,956,628	\$ 134,357		\$ 108,716	\$ (25,641)	\$ 1,001,628	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number River Park Healthcare Center

0042549

Report Period Beginning:

01/01/07

Ending:

12/31/07

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		\$ 3,956,628	\$ 134,357		\$ 108,716	\$ (25,641)	\$ 1,001,628	1
2									2
3									3
4									4
5									5
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,956,628	\$ 134,357		\$ 108,716	\$ (25,641)	\$ 1,001,628	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12G, Carried Forward		\$ 3,956,628	\$ 134,357		\$ 108,716	\$ (25,641)	\$ 1,001,628	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,956,628	\$ 134,357		\$ 108,716	\$ (25,641)	\$ 1,001,628	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number River Park Healthcare Center

0042549

Report Period Beginning:

01/01/07

Ending:

12/31/07

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		\$ 3,956,628	\$ 134,357		\$ 108,716	\$ (25,641)	\$ 1,001,628	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,956,628	\$ 134,357		\$ 108,716	\$ (25,641)	\$ 1,001,628	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number River Park Healthcare Center

0042549

Report Period Beginning:

01/01/07

Ending:

12/31/07

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12I, Carried Forward		\$ 3,956,628	\$ 134,357		\$ 108,716	\$ (25,641)	\$ 1,001,628	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,956,628	\$ 134,357		\$ 108,716	\$ (25,641)	\$ 1,001,628	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number River Park Healthcare Center

0042549

Report Period Beginning:

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Ending:

12/31/07

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12J, Carried Forward		\$ 3,956,628	\$ 134,357		\$ 108,716	\$ (25,641)	\$ 1,001,628	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
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29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,956,628	\$ 134,357		\$ 108,716	\$ (25,641)	\$ 1,001,628	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number River Park Healthcare Center

0042549

Report Period Beginning:

01/01/07

Ending:

12/31/07

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12K, Carried Forward		\$ 3,956,628	\$ 134,357		\$ 108,716	\$ (25,641)	\$ 1,001,628	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,956,628	\$ 134,357		\$ 108,716	\$ (25,641)	\$ 1,001,628	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number River Park Healthcare Center

0042549

Report Period Beginning:

01/01/07

Ending:

12/31/07

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12L, Carried Forward		\$ 3,956,628	\$ 134,357		\$ 108,716	\$ (25,641)	\$ 1,001,628	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
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29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,956,628	\$ 134,357		\$ 108,716	\$ (25,641)	\$ 1,001,628	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number River Park Healthcare Center

0042549

Report Period Beginning:

01/01/07

Ending:

12/31/07

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12M, Carried Forward		\$ 3,956,628	\$ 134,357		\$ 108,716	\$ (25,641)	\$ 1,001,628	1
2									2
3									3
4									4
5									5
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33									33
34	TOTAL (lines 1 thru 33)		\$ 3,956,628	\$ 134,357		\$ 108,716	\$ (25,641)	\$ 1,001,628	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number River Park Healthcare Center

0042549

Report Period Beginning:

01/01/07

Ending:

12/31/07

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12N, Carried Forward		\$ 3,956,628	\$ 134,357		\$ 108,716	\$ (25,641)	\$ 1,001,628	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,956,628	\$ 134,357		\$ 108,716	\$ (25,641)	\$ 1,001,628	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number River Park Healthcare Center

0042549

Report Period Beginning:

01/01/07

Ending:

12/31/07

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12O, Carried Forward		\$ 3,956,628	\$ 134,357		\$ 108,716	\$ (25,641)	\$ 1,001,628	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,956,628	\$ 134,357		\$ 108,716	\$ (25,641)	\$ 1,001,628	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number River Park Healthcare Center

0042549

Report Period Beginning:

01/01/07

Ending:

12/31/07

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12P, Carried Forward		\$ 3,956,628	\$ 134,357		\$ 108,716	\$ (25,641)	\$ 1,001,628	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,956,628	\$ 134,357		\$ 108,716	\$ (25,641)	\$ 1,001,628	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number River Park Healthcare Center

0042549

Report Period Beginning:

01/01/07

Ending:

12/31/07

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	177		1997	1975	\$ 3,596,265	\$ 92,208	39	\$ 92,208	\$	\$ 949,017	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9		Flooring, Wallcovering, Window Treatment, Doors		1997	66,202	1,698	20	3,310	1,612	19,677	9
10		Windows		1998	2,278	58	20	114	56	607	10
11		Walk in Freezer Compressor		2000	2,097	76	20	105	29	628	11
12		Electrical Work		2001	1,854	67	20	93	26	476	12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number River Park Healthcare Center

0042549

Report Period Beginning:

01/01/07

Ending:

12/31/07

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67								67
68								68
69								69
70	TOTAL (lines 4 thru 69)	\$ 3,668,696	\$ 94,107		\$ 95,830	\$ 1,723	\$ 970,405	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number River Park Healthcare Center

0042549

Report Period Beginning:

01/01/07

Ending:

12/31/07

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

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4		Allocate From SIR Properties- SIR Mgmt	1993	1993	\$ 7,087	\$ 225	35	\$ 202	\$ (23)	\$ 2,936	4
5		Allocate From SIR Properties-Preferred Bkkpg	1993	1993	5,114	162	35	146	(16)	2,118	5
6											6
7											7
8											8
		Improvement Type**									
9		Allocate From Preferred Bookkeeping	1997	1997	6,386	143	20	319	176	3,451	9
10		Allocate From Preferred Bookkeeping	1999	1999	51	-	20	3	3	22	10
11		Allocate From Preferred Bookkeeping	2000	2000	320	-	20	16	16	119	11
12											12
13		Allocate From SIR Management	1993	1993	3,044	85	20	151	66	2,264	13
14		Allocate From SIR Management	1994	1994	9	-	20	-		9	14
15		Allocate From SIR Management	1995	1995	70	-	20	3	3	43	15
16		Allocate From SIR Management	1999	1999	331	-	20	17	17	136	16
17		Allocate From SIR Management	2000	2000	200	-	20	10	10	77	17
18		Allocate From SIR Management	2007	2007	1,395	132	20	14	(118)	14	18
19											19
20		Allocate From SIR Properties-Preferred Bkkpg	2007	2007	90	4	20	4		4	20
21		Allocate From SIR Properties-Preferred Bkkpg	2002	2002	20	-	20	1	1	6	21
22		Allocate From SIR Properties-Preferred Bkkpg	1999	1999	648	65	20	32	(33)	275	22
23		Allocate From SIR Properties-Preferred Bkkpg	1998	1998	310	31	20	15	(16)	147	23
24		Allocate From SIR Properties-Preferred Bkkpg	1997	1997	19	1	20	1		11	24
25		Allocate From SIR Properties-Preferred Bkkpg	1994	1994	49	1	20	2	1	33	25
26		Allocate From SIR Properties-Preferred Bkkpg	1993	1993	83	-	20	4	4	60	26
27											27
28		Allocate From SIR Properties- SIR Mgmt	2007	2007	124	6	20	6		6	28
29		Allocate From SIR Properties- SIR Mgmt	2002	2002	28	-	20	1	1	8	29
30		Allocate From SIR Properties- SIR Mgmt	1999	1999	898	90	20	45	(45)	382	30
31		Allocate From SIR Properties- SIR Mgmt	1998	1998	429	43	20	21	(22)	204	31
32		Allocate From SIR Properties- SIR Mgmt	1997	1997	27	1	20	1		15	32
33		Allocate From SIR Properties- SIR Mgmt	1994	1994	67	2	20	3	1	46	33
34		Allocate From SIR Properties- SIR Mgmt	1993	1993	115	1	20	6	5	83	34
35											35
36											36

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number River Park Healthcare Center

0042549

Report Period Beginning:

01/01/07

Ending:

12/31/07

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	Allocated From Careplus Rehab- Fire Code Remodel	2003	\$ 36,915	\$	20	\$ 1,846	\$ 1,846	\$ 3,874	37
38	Allocated From Careplus Rehab- Fire Code Remodel	2004	30,078		20	1,504	1,504	3,021	38
39									39
40	Allocated From Careplus Management- LIMP	2004	57,519		20	2,876	2,876		40
41	Allocated From Careplus Management- LIMP	2004	22,597		20	1,130	1,130		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	Total Depreciation Careplus Rehab & Management			19,259			(19,259)		69
70	TOTAL (lines 4 thru 69)		\$ 174,023	\$ 20,251		\$ 8,378	\$ (11,873)	\$ 19,364	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number River Park Healthcare Center # 0042549 Report Period Beginning: 01/01/07 Ending: 12/31/07

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	\$ 282,188	\$ 205	\$ 26,840	\$ 26,635	10	\$ 200,346	71
72	Current Year Purchases	30,464	3,790	857	(2,933)	10	857	72
73	Fully Depreciated Assets	225,012				10	225,012	73
74								74
75	TOTALS	\$ 537,664	\$ 3,995	\$ 27,697	\$ 23,702		\$ 426,215	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Facility	98 Chevy Van	2001	\$ 13,000	\$	\$	\$	5	\$ 13,000	76
77										77
78										78
79										79
80	TOTALS			\$ 13,000	\$	\$	\$		\$ 13,000	80

E. Summary of Care-Related Assets

	1	Reference	2	
			Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 4,927,292	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 138,352	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 136,413	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (1,939)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,440,843	85

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

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

G. Construction-in-Progress

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

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

If NO, see instructions. YES NO

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

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

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

Fiscal Year Ending	Annual Rent
--------------------	-------------

12.	_____ /2008	\$ _____
13.	_____ /2009	\$ _____
14.	_____ /2010	\$ _____

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: \$ 10,432 Description: See Attached Schedule

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	<u>Allocate From SIR Management</u>		\$ _____	\$ <u>742</u>	17
18					18
19					19
20					20
21	TOTAL		\$ _____	\$ <u>742</u>	21

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

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

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39 - 03	hrs	\$		\$ 54,400	\$		\$ 54,400	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			6,009			6,009	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			119,331			119,331	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 02	# of prescripts				111,374		111,374	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): See Supplemental					40,491	2,942		43,433	13
14	TOTAL			\$		\$ 220,231	\$ 114,316		\$ 334,547	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number River Park Healthcare Center# 0042549Report Period Beginning: 01/01/07

Ending:

12/31/07

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/07

(last day of reporting year)

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

		1 Operating	2 After Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$ 26,684	\$ 332,929	1
2	Cash-Patient Deposits	36,027	36,027	2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	1,238,943	1,238,943	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	110,004	133,975	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>See Attached Schedule</u>	40,218	1,932,012	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,451,876	\$ 3,673,886	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		420,000	13
14	Buildings, at Historical Cost		3,596,265	14
15	Leasehold Improvements, at Historical Cost		72,431	15
16	Equipment, at Historical Cost	25,443	250,443	16
17	Accumulated Depreciation (book methods)	(3,306)	(1,196,986)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs		96,537	19
20	Accumulated Amortization - Organization & Pre-Operating Costs		(15,298)	20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <u>See Attached Schedule</u>			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 22,137	\$ 3,223,392	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,474,013	\$ 6,897,278	25

		1 Operating	2 After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 506,981	\$ 506,983	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	36,101	36,101	28
29	Short-Term Notes Payable	775,000	775,000	29
30	Accrued Salaries Payable	66,803	66,803	30
31	Accrued Taxes Payable (excluding real estate taxes)	15,676	15,676	31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable		22,186	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	<u>See Attached Schedule</u>	62,500	932,500	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,463,061	\$ 2,355,249	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable		1,801	39
40	Mortgage Payable		4,840,498	40
41	Bonds Payable			41
42	Deferred Compensation			42
Other Long-Term Liabilities(specify):				
43	<u>See Attached Schedule</u>			43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$ 4,842,299	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,463,061	\$ 7,197,548	46
47	TOTAL EQUITY(page 18, line 24)	\$ 10,952	\$ (300,270)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,474,013	\$ 6,897,278	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 740,843	1
2	Restatements (describe):		2
3	Net combining adjustments to retained earnings	(277,034)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 463,809	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(452,857)	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)	\$ (452,857)	17
B. Transfers (Itemize):			
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 10,952	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number River Park Healthcare Center

0042549

Report Period Beginning: 01/01/07

Ending: 12/31/07

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required

classifications of revenue and expense must be provided on this form, even if financial statements are attached.

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

		1	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 5,652,798	1
2	Discounts and Allowances for all Levels	(61,337)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 5,591,461	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	106,340	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 106,340	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	20,387	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	2,690	19
20	Radiology and X-Ray	504	20
21	Other Medical Services	67,102	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 90,683	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	2,384	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 2,384	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>See Supplemental Schedule</u>		28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 5,790,868	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	1,097,450	31
32	Health Care	2,178,644	32
33	General Administration	1,830,239	33
B. Capital Expense			
34	Ownership	676,251	34
C. Ancillary Expense			
35	Special Cost Centers	364,233	35
36	Provider Participation Fee	96,908	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 6,243,725	40
41	Income before Income Taxes (line 30 minus line 40)**	(452,857)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (452,857)	43

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

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

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

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

Facility Name & ID Number River Park Healthcare Center

0042549

Report Period Beginning:

01/01/07

Ending:

12/31/07

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	1,603	1,761	\$ 49,241	\$ 27.96	1
2	Assistant Director of Nursing	1,675	1,858	38,931	20.95	2
3	Registered Nurses	8,128	8,630	171,521	19.87	3
4	Licensed Practical Nurses	35,877	37,968	626,570	16.50	4
5	CNAs & Orderlies	69,960	71,010	726,401	10.23	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	14,247	15,252	177,440	11.63	8
9	Activity Director	667	694	9,270	13.36	9
10	Activity Assistants	7,725	8,357	81,638	9.77	10
11	Social Service Workers	1,233	1,311	23,856	18.20	11
12	Dietician					12
13	Food Service Supervisor	2,102	2,286	43,085	18.85	13
14	Head Cook	10,939	11,675	101,476	8.69	14
15	Cook Helpers/Assistants	10,254	10,391	77,934	7.50	15
16	Dishwashers					16
17	Maintenance Workers	4,005	4,316	55,833	12.94	17
18	Housekeepers	18,041	19,022	159,490	8.38	18
19	Laundry	8,233	8,772	68,607	7.82	19
20	Administrator	1,806	1,896	57,976	30.58	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	5,586	6,068	87,952	14.49	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	4,259	4,759	49,221	10.34	31
32	Other Health Care(specify)					32
33	Other(specify) <u>See Supplemental</u>	1,488	1,530	29,686	19.40	33
34	TOTAL (lines 1 - 33)	207,828	217,556	\$ 2,636,128 *	\$ 12.12	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	Monthly	\$ 10,064	01-03	35
36	Medical Director	Monthly	26,550	09-03	36
37	Medical Records Consultant	Monthly	1,000	10-03	37
38	Nurse Consultant	Monthly	11,684	10-03	38
39	Pharmacist Consultant	Monthly	600	10-03	39
40	Physical Therapy Consultant	Monthly	8,520	10a-03	40
41	Occupational Therapy Consultant	Monthly	6,800	10a-03	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	Monthly	5,035	12-03	45
46	Other(specify)				46
47	<u>Director of Food Service</u>	Monthly	6,016	01-03	47
48					48
49	TOTAL (lines 35 - 48)		\$ 76,269		49

C. CONTRACT NURSES

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number River Park Healthcare Center

0042549

Report Period Beginning: 01/01/07

Ending: 12/31/07

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	
<u>Dawn May</u>	<u>Administrator</u>	<u>0%</u>	\$ <u>57,976</u>	<u>Workers' Compensation Insurance</u>	\$ <u>77,941</u>	<u>IDPH License Fee</u>	\$ _____	
				<u>Unemployment Compensation Insurance</u>	<u>43,888</u>	<u>Advertising: Employee Recruitment</u>	<u>7,804</u>	
				<u>FICA Taxes</u>	<u>199,329</u>	<u>Health Care Worker Background Check</u>	<u>810</u>	
				<u>Employee Health Insurance</u>	<u>30,168</u>	(Indicate # of checks performed <u>81</u>)		
				<u>Employee Meals</u>	<u>15,023</u>	<u>Patient Background Checks</u>		
				<u>Illinois Municipal Retirement Fund (IMRF)*</u>		<u>License and Permit</u>	<u>2,308</u>	
				<u>Other Employee Benefits</u>	<u>7,113</u>	<u>Dues and Subscriptions</u>	<u>5,349</u>	
						<u>Advertising and Promotion</u>	<u>19,744</u>	
						<u>Allocate From Preferred</u>	<u>91</u>	
						<u>See Supplemental Schedule</u>	<u>2,650</u>	
						<u>Less: Public Relations Expense</u>	(_____)	
						<u>Non-allowable advertising</u>	<u>(19,744)</u>	
						<u>Yellow page advertising</u>	(_____)	
TOTAL (agree to Schedule V, line 17, col. 1)			\$ <u>57,976</u>	TOTAL (agree to Schedule V,	\$ <u>373,462</u>	TOTAL (agree to Sch. V,	\$ <u>19,012</u>	
(List each licensed administrator separately.)				line 22, col.8)		line 20, col. 8)		
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
<u>SIR Management- Director of Administrative Services</u>			\$ <u>7,432</u>			\$ _____	<u>Out-of-State Travel</u>	\$ _____
<u>SIR Management- Administrative Legal Services</u>			<u>4,780</u>					
<u>SIR Management- Ancillary Administrative Charges</u>			<u>13,280</u>					
<u>See Supplemental Schedule</u>			<u>1,440</u>				<u>In-State Travel</u>	
TOTAL (agree to Schedule V, line 17, col. 3)			\$ <u>26,932</u>					
(Attach a copy of any management service agreement)							<u>Seminar Expense</u>	<u>3,966</u>
							<u>Allocate From Preferred</u>	<u>9</u>
							<u>Allocate From SIR</u>	<u>71</u>
							<u>See Supplemental Schedule</u>	<u>1,061</u>
							<u>Entertainment Expense</u>	(_____)
							(agree to Sch. V,	
							line 24, col. 8)	
								\$ <u>5,107</u>
C. Professional Services				TOTAL		\$ _____		
Vendor/Payee	Type		Amount					
<u>Preferred Bookkeeping</u>	<u>Accounting</u>		\$ <u>14,000</u>					
<u>Preferred Bookkeeping</u>	<u>Bookkeeping</u>		<u>24,072</u>					
<u>Preferred Bookkeeping</u>	<u>Computer Support</u>		<u>1,416</u>					
<u>Personnel Planners</u>	<u>Unemployment Consult</u>		<u>2,463</u>					
<u>American Data</u>	<u>MDS</u>		<u>922</u>					
<u>Halg & Associates</u>	<u>Computer Services</u>		<u>752</u>					
<u>HDSI</u>	<u>Data Processing</u>		<u>2,250</u>					
<u>Frost, Ruttenberg & Rothblatt</u>	<u>Accounting</u>		<u>575</u>					
<u>Duane Morris</u>	<u>Legal</u>		<u>5,000</u>					
<u>Honkamp Krueger</u>	<u>WOTC Program</u>		<u>11,560</u>					
<u>SAK</u>	<u>Management Service</u>		<u>693</u>					
<u>See Supplemental Schedule</u>			<u>199,462</u>					
TOTAL (agree to Schedule V, line 19, column 3)			\$ <u>263,165</u>					
(If total legal fees exceed \$5,000, attach copy of invoices.)								

* Attach copy of IMRF notifications
SEE ACCOUNTANTS' COMPILATION REPORT

**See instructions.

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

	1 Improvement Type	2 Month & Year Improvement Was Made	3 Total Cost	4 Useful Life	Amount of Expense Amortized Per Year								
					5 FY2004	6 FY2005	7 FY2006	8 FY2007	9 FY2008	10 FY2009	11 FY2010	12 FY2011	13 FY2012
1	N/A		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

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. N/A
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 10 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 1,155 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 96,908
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 15,023 Has any meal income been offset against related costs? No Indicate the amount. \$ N/A
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
c. What percent of all travel expense relates to transportation of nurses and patients? 100%ln14
d. Have vehicle usage logs been maintained? 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: N/A The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? N/A If no, please explain. N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? N/A
Attach invoices and a summary of services for all architect and appraisal fees.

SEE ACCOUNTANTS' COMPILATION REPORT