

Facility Name & ID Number OAK PARK HEALTHCARE CENTER

0044602 Report Period Beginning: 01/01/2008 Ending: 12/31/2008

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	204	Skilled (SNF)	204	74,664	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	204	TOTALS	204	74,664	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF			3,916	3,916	8
9	SNF/PED					9
10	ICF	49,865	603		50,468	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	49,865	603	3,916	54,384	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 72.84%

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

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

NONE

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

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

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

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

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

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 204 and days of care provided 3,916

Medicare Intermediary ADMINASTAR

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/2008 Fiscal Year: 12/31/2008

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

Facility Name & ID Number **OAK PARK HEALTHCARE CENTER** # **0044602** Report Period Beginning: **01/01/2008** Ending: **12/31/2008**

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	202,636	34,744	13,835	251,215		251,215		251,215		1
2	Food Purchase		242,870		242,870	(15,262)	227,608	(721)	226,887		2
3	Housekeeping	158,647	39,796		198,443		198,443		198,443		3
4	Laundry	64,331	20,332		84,663		84,663		84,663		4
5	Heat and Other Utilities			204,487	204,487		204,487	107	204,594		5
6	Maintenance	48,021	29,191	50,687	127,899		127,899	18,391	146,290		6
7	Other (specify):* SECURITY	15,581		17,199	32,780		32,780	45	32,825		7
8	TOTAL General Services	489,216	366,933	286,208	1,142,357	(15,262)	1,127,095	17,822	1,144,917		8
	B. Health Care and Programs										
9	Medical Director			4,000	4,000		4,000		4,000		9
10	Nursing and Medical Records	2,093,366	107,174	3,590	2,204,130		2,204,130	41,200	2,245,330		10
10a	Therapy	112,547	11,308	115,286	239,141		239,141	6,778	245,919		10a
11	Activities	90,652	5,654	2,564	98,870		98,870		98,870		11
12	Social Services	36,391		1,815	38,206		38,206		38,206		12
13	CNA Training										13
14	Program Transportation			80	80		80		80		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	2,332,956	124,136	127,335	2,584,427		2,584,427	47,978	2,632,405		16
	C. General Administration										
17	Administrative	133,683		72,000	205,683		205,683	61,065	266,748		17
18	Directors Fees										18
19	Professional Services			310,468	310,468		310,468	(216,185)	94,283		19
20	Dues, Fees, Subscriptions & Promotions			32,595	32,595		32,595	(6,606)	25,989		20
21	Clerical & General Office Expenses	66,365	22,916	223,652	312,933		312,933	(55,439)	257,494		21
22	Employee Benefits & Payroll Taxes			488,391	488,391	15,262	503,653		503,653		22
23	Inservice Training & Education			4,916	4,916		4,916	2,423	7,339		23
24	Travel and Seminar							89	89		24
25	Other Admin. Staff Transportation			1,173	1,173		1,173	14,432	15,605		25
26	Insurance-Prop.Liab.Malpractice			160,487	160,487		160,487	2,784	163,271		26
27	Other (specify):* MARKETING	50,894			50,894		50,894	11,966	62,860		27
28	TOTAL General Administration	250,942	22,916	1,293,682	1,567,540	15,262	1,582,802	(185,471)	1,397,331		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,073,114	513,985	1,707,225	5,294,324		5,294,324	(119,671)	5,174,653		29

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

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

V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE	SCHED REF	TOTAL
1	DIETARY	
	DIETITIAN CONSULTANT XVIII B 35-2	11,853
	REPAIRS & MAINTENANCE	1,982
		0
		13,835
3	HOUSEKEEPING	
		0
		0
		0
4	LAUNDRY	
	EQUIPMENT REPAIRS & MAINTENANCE	0
		0
		0
5	HEAT & OTHER UTILITIES	
	GAS HEAT	78,610
	ELECTRICITY	71,638
	WATER	54,239
	CABLE TV - LOBBY	0
		0
		204,487
6	MAINTENANCE	
	GROUND MAINTENANCE	3,199
	PAINTING & DECORATING	0
	BUILDING REPAIRS	0
	MAINTENANCE TRAVEL	0
	EQUIPMENT MAINTENANCE & REPAIR	23,408
	ELEVATOR MAINTENANCE & REPAIR	14,352
	OUTSIDE LABOR	0
	EXTERMINATING SERVICE	3,739
	FIRE SERVICE	5,989
		0
		0
		0
		0
		50,687
7	OTHER	
	SCAVENGER	17,199
	SECURITY SERVICE	0
		0
		0
		17,199
9	MEDICAL DIRECTOR	
	MEDICAL DIRECTOR FEES XVIII B 36-2	4,000
		4,000

LINE	SCHED REF	TOTAL
10	NURSING	
	CONTRACT NURSING XVIII C 53-2	
	LABORATORY & XRAY EXPENSE	0
	PURCHASED SERVICES	0
	PSYCHO-SOCIAL CONSULTANT XVIII B ___-2	0
	RESTORATIVE NURSING CONSULTANT XVIII B 38-2	0
	MEDICAL RECORDS CONSULTANT XVIII B 37-2	1,472
	PHARMACY CONSULTANT XVIII B 39-2	2,118
	UTILIZATION REVIEW FEES XVIII B ___-2	0
	PHYSICIANS XVIII B ___-2	0
	PSYCHIATRIC XVIII B ___-2	0
	RN CONSULTANT XVIII B 38-2	0
	DENTAL SERVICES	0
		0
		3,590
10a	THERAPY	
	PHYSICAL THERAPY SERVICES	7,869
	SPEECH THERAPY SERVICES	7,623
	OCCUPATIONAL THERAPY SERVICES	16,271
	REHABILITATION CONSULTANT XVIII B ___-2	0
	PHYSICAL THERAPY CONSULTANT XVIII B 40-2	7,200
	OCCUPATIONAL THERAPY CONSULTA XVIII B 41-2	7,200
	RESPIRATORY THERAPY CONSULTAN XVIII B 42-2	0
	SPEECH THERAPY CONSULTANT XVIII B 43-2	0
	THERAPY CONTRACT SERVICES	69,123
		115,286
11	ACTIVITIES	
	CABLE TV - PATIENT ROOMS	
	ACTIVITY REHAB CONSULTANT XVIII B 44-2	2,564
		0
		2,564
12	SOCIAL SERVICES	
	SOCIAL REHABILITATION SERVICES	1,815
	SOCIAL REHABILITATION CONSULTAN XVIII B 45-2	0
	SOCIAL WORKER XVIII B 45-2	0
		0
		1,815
13	NURSE AIDE TRAINING	
	NURSE AIDE TRAINING COSTS XIII	0
		0

V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE	SCHED REF	TOTAL
14	PROGRAM TRANSPORTATION	
	PATIENT TRANSPORTATION	80
17	ADMINISTRATIVE	
	MANAGEMENT FEES XIX B	72,000
	DIRECTORS FEES	
18	DIRECTORS FEES	0
19	PROFESSIONAL SERVICES	
	DATA PROCESSING XIX C	55,727
	ADMINISTRATIVE CONSULTANTS XIX C	198,000
	PROFESSIONAL FEES XIX C	56,741
		0
		310,468
20	FEES,SUBSCRIPTIONS,PROMOTIONS	
	ENTERTAINMENT & MARKETING VI 19 XIX F	0
	ADV & PROMO-NON PATIENT RELATED VI 25 XIX F	10,260
	EMPLOYEE WANT ADS XIX F	15,455
	CONTRIBUTIONS VI 20 XIX F	0
	DUES & SUBSCRIPTIONS XIX F	1,224
	LICENSES & PERMITS XIX F	4,698
	PUBLIC RELATIONS-PATIENT RELATED XIX F	0
	ADVERTISING-YELLOW PAGES VI 28 XIX F	258
	TRUST FEES / FRANCHISE TAX / ETC VI 17 XIX F	700
	CONTRIBUTIONS - POLITICAL VI 20 XIX F	0
	HEALTH CARE WORKER BACKGROUND CHEC XIX F	0
	PATIENT BACKGROUND CHECKS XIX F	0
		32,595
21	CLERICAL & GENERAL OFFICE EXPENSES	
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)	0
	EQUIPMENT REPAIR & MAINTENANCE	10,853
	OUTSIDE CLERICAL SERVICES	122,400
	PENALTIES / OVERDRAFT CHARGES VI 18	50,642
	HOME OFFICE EXPENSE	0
	THEFT & DAMAGE LOSS	9,437
	TELEPHONE	19,035
	MESSENGER SERVICE	11,285
		0
		223,652

LINE	SCHED REF	TOTAL
22	EMPLOYEE BENEFITS & PAYROLL TAXES	
	FICA TAXES XIX D	233,134
	UNEMPLOYMENT COMPENSATION XIX D	46,784
	WORKERS COMPENSATION INSURANC XIX D	99,367
	HOSPITALIZATION INSURANCE XIX D	91,915
	EMPLOYEE BENEFITS - OTHER XIX D	16,796
	EMPLOYEE PHYSICAL EXAMS XIX D	395
	INSURANCE - EXECUTIVE LIFE VI 21/XIX D	0
	PENSION/PROFIT SHARING PLANS XIX D	0
	CHICAGO HEAD TAX XIX D	0
		0
		488,391
23	INSERVICE TRAINING & EDUCATION	
	EDUCATION & SEMINARS	4,916
		4,916
24	TRAVEL & SEMINARS	
	EDUCATION & SEMINARS XIX G	0
	TRAVEL XIX G	0
		0
25	ADMIN. STAFF TRANSPORTATION	
	TRANSPORTATION - STAFF	1,173
		1,173
26	INSURANCE - PROP. LIAB & MALPRACTICE	
	GENERAL INSURANCE	112,627
	GENERAL INSURANCE EXPENSE	7,860
	INSURANCE SETTLEMENTS	40,000
		160,487
27	OTHER	
	BAD DEBTS VI 24	0
		0

GRAND TOTAL COLUMN 3 OTHER

1,707,225

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY	
		Salary/Wage	Supplies	Other	Total					9	10
	D. Ownership	1	2	3	4	5	6	7	8		
30	Depreciation			116,571	116,571		116,571	(38,906)	77,665		30
31	Amortization of Pre-Op. & Org.										31
32	Interest			575,558	575,558		575,558	36,099	611,657		32
33	Real Estate Taxes			389,139	389,139		389,139	9,093	398,232		33
34	Rent-Facility & Grounds			630,128	630,128		630,128		630,128		34
35	Rent-Equipment & Vehicles			30,356	30,356		30,356	10,054	40,410		35
36	Other (specify):* OFFICE RENT			24,000	24,000		24,000	(24,000)			36
37	TOTAL Ownership			1,765,752	1,765,752		1,765,752	(7,660)	1,758,092		37
	Ancillary Expense										
	E. Special Cost Centers										
38	Medically Necessary Transportation										38
39	Ancillary Service Centers		140,736	303,362	444,098		444,098		444,098		39
40	Barber and Beauty Shops										40
41	Coffee and Gift Shops										41
42	Provider Participation Fee			111,996	111,996		111,996		111,996		42
43	Other (specify):*										43
44	TOTAL Special Cost Centers		140,736	415,358	556,094		556,094		556,094		44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,073,114	654,721	3,888,335	7,616,170		7,616,170	(127,331)	7,488,839		45

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

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	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				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(52,678)	30		9
10	Interest and Other Investment Income	(2,077)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(721)	2		13
14	Non-Care Related Interest	(15,433)	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees	(700)	20		17
18	Fines and Penalties	(50,642)	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				24
25	Fund Raising, Advertising and Promotional	(10,260)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(258)	20		28
29	Other-Attach Schedule <u>MARKETING SALARIES</u>	(50,894)	27		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (183,663)		\$	30

BHF USE ONLY							
48		49		50		51	

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)	56,332		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 56,332		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (127,331)		37

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

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

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

OAK PARK HEALTHCARE CENTER

ID# 0044602

Report Period Beginning: 01/01/2008

Ending: 12/31/2008

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
1	MARKETING SALARIES	\$ (50,894)	27
2			2
3			3
4			4
5			5
6			6
7			7
8			8
9			9
10			10
11			11
12			12
13			13
14			14
15			15
16			16
17			17
18			18
19			19
20			20
21			21
22			22
23			23
24			24
25			25
26			26
27			27
28			28
29			29
30			30
31			31
32			32
33			33
34			34
35			35
36			36
37			37
38			38
39			39
40			40
41			41
42			42
43			43
44			44
45			45
46			46
47			47
48			48
49	Total	(50,894)	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number OAK PARK HEALTHCARE CENTER

0044602

Report Period Beginning:

01/01/2008

Ending:

12/31/2008

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(721)	0	0	0	0	0	0	0	0	0	0	(721)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	107	0	0	0	0	0	0	0	0	0	107	5
6	Maintenance	0	18,391	0	0	0	0	0	0	0	0	0	18,391	6
7	Other (specify):*	0	45	0	0	0	0	0	0	0	0	0	45	7
8	TOTAL General Services	(721)	18,543	0	0	0	0	0	0	0	0	0	17,822	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	41,200	0	0	0	0	0	0	0	0	0	41,200	10
10a	Therapy	0	6,778	0	0	0	0	0	0	0	0	0	6,778	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	47,978	0	0	0	0	0	0	0	0	0	47,978	16
	C. General Administration													
17	Administrative	0	61,065	0	0	0	0	0	0	0	0	0	61,065	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	(216,185)	0	0	0	0	0	0	0	0	0	(216,185)	19
20	Fees, Subscriptions & Promotions	(11,218)	4,612	0	0	0	0	0	0	0	0	0	(6,606)	20
21	Clerical & General Office Expenses	(50,642)	(122,400)	117,603	0	0	0	0	0	0	0	0	(55,439)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	2,423	0	0	0	0	0	0	0	0	2,423	23
24	Travel and Seminar	0	0	89	0	0	0	0	0	0	0	0	89	24
25	Other Admin. Staff Transportation	0	0	14,432	0	0	0	0	0	0	0	0	14,432	25
26	Insurance-Prop.Liab.Malpractice	0	0	2,784	0	0	0	0	0	0	0	0	2,784	26
27	Other (specify):*	(50,894)	0	62,860	0	0	0	0	0	0	0	0	11,966	27
28	TOTAL General Administration	(112,754)	(272,908)	200,191	0	(185,471)	28							
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(113,475)	(206,387)	200,191	0	(119,671)	29							

STATE OF ILLINOIS

Summary B

Facility Name & ID Number OAK PARK HEALTHCARE CENTER

0044602

Report Period Beginning:

01/01/2008

Ending:

12/31/2008

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I		
30	Depreciation	(52,678)	0	13,772	0	0	0	0	0	0	0	0	(38,906)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(17,510)	0	53,609	0	0	0	0	0	0	0	0	36,099	32
33	Real Estate Taxes	0	0	9,093	0	0	0	0	0	0	0	0	9,093	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	10,054	0	0	0	0	0	0	0	0	10,054	35
36	Other (specify):*	0	(24,000)	0	0	0	0	0	0	0	0	0	(24,000)	36
37	TOTAL Ownership	(70,188)	(24,000)	86,528	0	(7,660)	37							
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(183,663)	(230,387)	286,719	0	(127,331)	45							

VII. RELATED PARTIES

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

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

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
1	V	17	MANAGEMENT FEES	\$ 72,000	CAREPLUS MGMT INC			(72,000)	1
2	V	19	ADMIN. CONSULTANT FEES	198,000	" "			(198,000)	2
3	V	19	DATA PROCESSING FEES	37,968	" "			(37,968)	3
4	V	21	CLERICAL FEES	122,400	" "			(122,400)	4
5	V	36	OFFICE RENT	24,000	" "			(24,000)	5
6	V	5	UTILITIES		" "		107	107	6
7	V	6	MAINTENANCE		" "		18,391	18,391	7
8	V	7	SECURITY		" "		45	45	8
9	V	10	NURSING		" "		41,200	41,200	9
10	V	10a	THERAPY		" "		6,778	6,778	10
11	V	17	ADMIN		" "		133,065	133,065	11
12	V	19	PROFESSIONAL FEES		" "		19,783	19,783	12
13	V	20	DUES/LICENSES/WANT ADS		" "		4,612	4,612	13
14	Total		\$ 454,368			\$ 223,981	\$ *	(230,387)	14

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	21 OFFICE	\$	CAREPLUS MGMT INC		\$ 117,603	\$ 117,603
16	V	23 SEMINARS		" "		2,423	2,423
17	V	24 IN-STATE TRAVEL/LODGING		" "		89	89
18	V	25 TRANSPORTATION		" "		14,432	14,432
19	V	26 INSURANCE		" "		2,784	2,784
20	V	27 EMPLOYEE BENEFITS		" "		62,860	62,860
21	V	30 SL DEPRECIATION		" "		10,800	10,800
22	V	32 INTEREST		" "		53,105	53,105
23	V	33 REAL ESTATE TAX		" "		9,093	9,093
24	V	35 EQUIPMENT RENT		" "		10,054	10,054
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V	30 SL DEPRECIATION		CAREPLUS REHABILITATIVE SERVICES		2,972	2,972
36	V	32 INTEREST		" "		504	504
37	V						
38	V						
39	Total		\$			\$ 286,719	\$ * 286,719

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

Facility Name & ID Number OAK PARK HEALTHCARE CENTER # 0044602 Report Period Beginning: 01/01/2008 Ending: 12/31/2008

VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	CAREPLUS MGMT ALLOCATIONS:								\$		1
2	SHERWIN RAY	PRESIDENT	ADMIN/FINANCE	50.00	SEE ATTACHED	8.7	14.54	SALARY	28,362	17-7	2
3	JAKOB BAKST	DIR OPERAT'NS	ADMIN/CONS.	50.00	SCHEDULES	8.7	14.54	" "	28,362	17-7	3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 56,724		13

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

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

Facility Name & ID Number OAK PARK HEALTHCARE CENTER

0044602

Report Period Beginning:

01/01/2008

Ending: 2/31/2008

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	5	UTILITIES	373,906	10 FACILITIES	\$ 739	\$	54,384	\$ 107	1
2	6	MAINTENANCE	373,906	10 FACILITIES	126,444	52,396	54,384	18,391	2
3	7	SECURITY	373,906	10 FACILITIES	308		54,384	45	3
4	10	NURSING	373,906	10 FACILITIES	283,260	283,260	54,384	41,200	4
5	10a	THERAPY	373,906	10 FACILITIES	46,604	46,472	54,384	6,778	5
6	17	ADMIN SALARIES	373,906	10 FACILITIES	914,862	914,862	54,384	133,065	6
7	19	PROFESSIONAL FEES	373,906	10 FACILITIES	136,016		54,384	19,783	7
8	20	DUES/LICENSES/WANT ADS	373,906	10 FACILITIES	31,710		54,384	4,612	8
9	21	OFFICE EXPENSES	373,906	10 FACILITIES	808,558	628,409	54,384	117,603	9
10	23	SEMINARS	373,906	10 FACILITIES	16,659		54,384	2,423	10
11	24	TRAVEL	373,906	10 FACILITIES	612		54,384	89	11
12	25	TRANSPORTATION	373,906	10 FACILITIES	99,225		54,384	14,432	12
13	26	INSURANCE	373,906	10 FACILITIES	19,140		54,384	2,784	13
14	27	EMPLOYEE BENEFITS	373,906	10 FACILITIES	432,184		54,384	62,860	14
15	30	SL DEPRECIATION	373,906	10 FACILITIES	74,261		54,384	10,800	15
16	32	INTEREST-TAG MTG/LOC/EQ LOAN	373,906	10 FACILITIES	365,115		54,384	53,105	16
17	33	REAL ESTATE TAX	373,906	10 FACILITIES	62,515		54,384	9,093	17
18	35	EQUIP RENT/AUTO LEASE	373,906	10 FACILITIES	69,127		54,384	10,054	18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 3,487,339	\$ 1,925,399		\$ 507,224	25

Facility Name & ID Number

OAK PARK HEALTHCARE CENTER

0044602

Report Period Beginning:

01/01/2008

Ending:

12/31/2008

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	Name of Lender	2		3	4	5	6		7	8	9	10					
		Related**					Monthly Payment Required	Date of Note					Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO										Original	Balance			
A. Directly Facility Related																	
Long-Term																	
1	CAREPLUS MGMT ALLOCATION: TAG MTG INT/LOC/EQ LOAN						\$	\$			\$	53,105					
2	CAREPLUS REHAB ALLOCATION: EQUIPMENT LOANS											504					
3																	
4																	
5																	
Working Capital																	
6	CAREPLUS MGMT - HFG	X		WORKING CAPITAL	DEMAND	01/04	3,370,000			PRIME+		560,022					
7	INSURANCE FINANCING		X									103					
8																	
9	TOTAL Facility Related						\$ 3,370,000	\$				\$ 613,734					
B. Non-Facility Related*																	
10	IRS, IDR, ETC		X	LATE FEES								15,433					
11																	
12																	
13																	
14	TOTAL Non-Facility Related						\$	\$				\$ 15,433					
15	TOTALS (line 9+line14)						\$ 3,370,000	\$				\$ 629,167					

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

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

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

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

B. Real Estate Taxes

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

1. Real Estate Tax accrual used on 2007 report.	\$	373,410	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	\$	379,379	2
3. Under or (over) accrual (line 2 minus line 1).	\$	5,969	3
4. Real Estate Tax accrual used for 2008 report. (Detail and explain your calculation of this accrual on the lines below.)	\$	383,170	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)	\$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)	\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	\$	389,139	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2003	269,947	8
	2004	290,912	9
	2005	360,382	10
	2006	369,715	11
	2007	379,379	12

FOR BHF USE ONLY			
13	FROM R. E. TAX STATEMENT FOR 2007	\$	13
14	PLUS APPEAL COST FROM LINE 5	\$	14
15	LESS REFUND FROM LINE 6	\$	15
16	AMOUNT TO USE FOR RATE CALCULATION	\$	16

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

THE PAYMENT ON LINE 2 APPLIES TO THE 2007 TAX BILL.

NOTES:

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

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2007 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 2007 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2007.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2007 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 2008 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.

2007 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME OAK PARK HEALTHCARE CENTER COUNTY COOK

FACILITY IDPH LICENSE NUMBER 0044602

CONTACT PERSON REGARDING THIS REPORT BOB KAGDA

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

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2007 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 2007.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>16-07-106-004-0000</u>	<u>NURSING HOME</u>	\$ <u>75,523.86</u>	\$ <u>75,523.86</u>
2. <u>16-07-106-005-0000</u>	<u>NURSING HOME</u>	\$ <u>73,189.62</u>	\$ <u>73,189.62</u>
3. <u>16-07-106-022-0000</u>	<u>NURSING HOME</u>	\$ <u>230,665.07</u>	\$ <u>230,665.07</u>
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>379,378.55</u>	\$ <u>379,378.55</u>

B. Real Estate Tax Cost Allocations

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

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

C. Tax Bills

Attach a copy of the original 2007 tax bills which were listed in Section A to this statement. Be sure to use the 2007 tax bill which is normally paid during 2008.

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

Facility Name & ID Number OAK PARK HEALTHCARE CENTER

0044602

Report Period Beginning:

01/01/2008 Ending:

12/31/2008

X. BUILDING AND GENERAL INFORMATION:

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

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

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

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

N/A

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

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

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

XI. OWNERSHIP COSTS:

A. Land.

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

Facility Name & ID Number OAK PARK HEALTHCARE CENTER

0044602

Report Period Beginning:

01/01/2008 Ending: 12/31/2008

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4				\$	\$		\$	\$	\$
5									
6									
7									
8									
	Improvement Type**								
9	NEW WINDOWS / LIGHT FIXTURES / GENERATOR		1999	74,653	1,914	39	1,914		17,321
10	WINDOWS / FENCE / CEILING		2000	13,360	486	27.5	486		4,354
11	WINDOWS / SIGNS / FLOORING / WALLPAPER		2000	42,672	1,552	27.5	1,552		13,747
12	WINDOWS / FLOORING / WALLPAPER / NURSE STATION		2000	29,709	1,080	27.5	1,080		9,405
13	FLOORING / DOORS / WALLS / HVAC SYSTEM		2000	56,310	2,047	27.5	2,047		17,656
14	WINDOWS / FLOORING / RAILS / ASPHALT PAVING		2000	30,160	1,096	27.5	1,096		9,322
15	WINDOWS / PLUMBING / PAINTING & DECORATING		2000	41,459	1,508	27.5	1,508		12,452
16	WINDOW TREATMENTS		2000	15,445	2	15	1,030	1,028	8,755
17	WINDOWS / WALK-IN FREEZER, ROOF & A/C REPAIRS		2001	23,850	868	27.5	868		6,668
18	WINDOWS / FLOORING / ALARM & PAGING SYSTEM		2001	9,926	361	27.5	361		2,565
19	WINDOWS / DOORS / GREASE TRAP / ROOF A/C		2002	62,212	2,266	27.5	2,266		14,735
20	WINDOWS / BACKFLOW PREVENTORS / AC TOWER BEARING		2003	16,526	603	27.5	603		3,473
21	CIRCUITS / ROOFTOP A/C MOTORS		2004	3,382	123	27.5	123		570
22	WINDOWS		2004	7,200	262	27.5	262		1,112
23	REMODEL MOLDINGS / HANDRAILS / CABINETRY / DECOR		2004	68,233	2,480	27.5	2,480		10,589
24	LIGHTING / NSG STNS / BATHRMS / FLOORS / RAILS / MOLDINGS		2005	321,276	11,683	27.5	11,683		38,204
25	WINDOWS / DOORS / ROOF / SIDING / PORCH / PATIO		2005	164,807	5,993	27.5	5,993		20,026
26	LANDSCAPING		2005	16,610	1,108	15	1,108		3,877
27	ROOM SIGNS / HAND RAILS / LIGHTING / EXHAUST / TILE		2006	22,383	813	27.5	813		2,229
28	ROOFTOP A/C PUMP		2007	4,059	148	27.5	148		240
29	PARKING LOT PAVING / WINDOW TREATMENTS		2007	5,887	997	15	393	(604)	589
30	ELEVATOR POWER UNIT / ROOF EXHAUSTS / PIPES / KICKPLT		2008	20,387	450	27.5	450		450
31	REMODELING SHOWERS / DRYWALL / FLOORS		2008	108,483	1,480	27.5	1,480		1,480
32	CONCRETE		2008	1,600	53	15	53		53
33									
34									
35									
36									

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

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

See Page 12A, Line 70 for total

XI. OWNERSHIP COSTS (continued)

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	\$ 281,529	\$ 29,653	\$ 20,700	\$ (8,953)	8-15 YRS	\$ 106,513	71
72	Current Year Purchases	79,242	47,545	3,396	(44,149)	8-15 YRS	3,396	72
73	Fully Depreciated Assets							73
74	**REL'D PARTY-SL DEPN:CAREPL MGT, 6,796 /CP REHAB, 2,866		9,662	9,662				74
75	TOTALS	\$ 360,771	\$ 86,860	\$ 33,758	\$ (53,102)		\$ 109,909	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				\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 1,582,881	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 130,343	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 77,665	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (52,678)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 316,392	85

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

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

G. Construction-in-Progress

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

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

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

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

If NO, see instructions. YES NO

	1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:	204	11/01/99	\$ 630,128			3
4	Additions						4
5							5
6							6
7	TOTAL	204		\$ 630,128			7

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

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

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

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

15. Is Movable equipment rental included in building rental?

YES NO

16. Rental Amount for movable equipment: \$ **24,435** Description: **SEE SCHEDULE ATTACHED**

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	ACTIVITY/HSKP/	2003 CHEVY EXPR 15P	\$ 587.55	\$ 5,921	17
18	MAINT				18
19					19
20					20
21	TOTAL		\$ 587.55	\$ 5,921	21

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

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

Fiscal Year Ending Annual Rent

12. _____/2009 \$ _____

13. _____/2010 \$ _____

14. _____/2011 \$ _____

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

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

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39-3	hrs	\$		\$ 115,755	\$		\$ 115,755	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			69,298			69,298	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			118,309			118,309	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescripts				140,016		140,016	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	MED.SUPPLIES/RADIOLOGY Other (specify):	39-2					720		720	13
14	TOTAL			\$		\$ 303,362	\$ 140,736		\$ 444,098	14

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

Facility Name & ID Number OAK PARK HEALTHCARE CENTER

0044602

Report Period Beginning: 01/01/2008

Ending: 12/31/2008

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2008

(last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (115,000))	4,492,513		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	82,730		6
7	Other Prepaid Expenses	12,082		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): R.E.TAX ESCROW	242,118		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 4,829,443	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	1,037,218		15
16	Equipment, at Historical Cost	375,659		16
17	Accumulated Depreciation (book methods)	(493,205)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): SECURITY DEPOSITS	5,818		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 925,490	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 5,754,933	\$	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 850,303	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	130,130		28
29	Short-Term Notes Payable	9,789,525		29
30	Accrued Salaries Payable	150,072		30
31	Accrued Taxes Payable (excluding real estate taxes)	19,930		31
32	Accrued Real Estate Taxes(Sch.IX-B)	383,170		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 11,323,130	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	<u>DUE TO BUILDING LLC</u>	72,658		43
44	<u>MEMBER LOANS PAYABLE</u>	1,330,000		44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 1,402,658	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 12,725,788	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ (6,970,855)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 5,754,933	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (6,763,046)	1
2	Restatements (describe):		2
3			3
4	ROUNDING	4	4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (6,763,042)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(207,813)	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)	\$ (207,813)	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)	\$ (6,970,855)	24 *

* This must agree with page 17, line 47.

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

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

1

	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 7,406,280	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 7,406,280	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	2,077	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 2,077	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 7,408,357	30

2

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,142,357	31
32	Health Care	2,584,427	32
33	General Administration	1,567,540	33
	B. Capital Expense		
34	Ownership	1,765,752	34
	C. Ancillary Expense		
35	Special Cost Centers	444,098	35
36	Provider Participation Fee	111,996	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 7,616,170	40
41	Income before Income Taxes (line 30 minus line 40)**	(207,813)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (207,813)	43

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

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

TAX RETURN PREPARED ON CASH BASIS

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

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

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

0044602

Report Period Beginning: 01/01/2008

Ending:

12/31/2008

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	1,815	2,226	\$ 77,095	\$ 34.63	1
2	Assistant Director of Nursing	1,985	2,491	75,671	30.38	2
3	Registered Nurses	8,721	9,134	248,995	27.26	3
4	Licensed Practical Nurses	30,289	31,974	752,978	23.55	4
5	CNAs & Orderlies	69,227	77,475	825,880	10.66	5
6	CNA Trainees					6
7	Licensed Therapist	1,701	1,794	46,194	25.75	7
8	Rehab/Therapy Aides	5,604	6,178	66,353	10.74	8
9	Activity Director	1,790	1,898	27,635	14.56	9
10	Activity Assistants	5,475	6,270	63,017	10.05	10
11	Social Service Workers	1,833	1,921	36,391	18.94	11
12	Dietician					12
13	Food Service Supervisor	1,563	1,713	32,969	19.25	13
14	Head Cook	2,705	3,058	35,928	11.75	14
15	Cook Helpers/Assistants	13,441	14,745	133,739	9.07	15
16	Dishwashers					16
17	Maintenance Workers	4,319	5,313	48,021	9.04	17
18	Housekeepers	14,593	16,513	158,647	9.61	18
19	Laundry	4,991	5,924	64,331	10.86	19
20	Administrator	1,991	2,225	93,297	41.93	20
21	Assistant Administrator	2,012	2,106	40,386	19.18	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	6,323	6,708	66,365	9.89	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,897	2,105	21,916	10.41	31
32	Other Health C: MDS/CPC	3,713	4,081	90,831	22.26	32
33	Other(specify) SECURITY/MKT	3,249	3,533	66,475	18.82	33
34	TOTAL (lines 1 - 33)	189,237	209,385	\$ 3,073,114 *	\$ 14.68	34

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

** See instructions.

B. CONSULTANT SERVICES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference		
35	Dietary Consultant	M	\$ 11,853	1-3	35
36	Medical Director	O	4,000	9-3	36
37	Medical Records Consultant	N	1,472	10-3	37
38	Nurse Consultant	T	0	10-3	38
39	Pharmacist Consultant	H	2,118	10-3	39
40	Physical Therapy Consultant	L	7,200	10a-3	40
41	Occupational Therapy Consultant	Y	7,200	10a-3	41
42	Respiratory Therapy Consultant		0	10a-3	42
43	Speech Therapy Consultant	F	0	10a-3	43
44	Activity Consultant	E	2,564	11-3	44
45	Social Service Consultant	E	0	12-3	45
46	Other(specify)	S			46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 36,407		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

Facility Name & ID Number OAK PARK HEALTHCARE CENTER

0044602

Report Period Beginning: 01/01/2008

Ending: 12/31/2008

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? YES
- (2) Are there any dues to nursing home associations included on the cost report? YES
If YES, give association name and amount. IL ASSOC HEALTHCARE FACIL \$1,224
- (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? _____
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? YES
What was the average life used for new equipment added during this period? 10 YR
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ _____ Line 10-2
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? NO
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? _____ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 111,996
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. \$ 15,262 Has any meal income been offset against related costs? N/A Indicate the amount. \$ _____
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? NO
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? 5%
d. Have vehicle usage logs been maintained? NO
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? NO
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? YES
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? NO
Firm Name: _____ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? _____ If no, please explain. _____
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? YES
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? YES
Attach invoices and a summary of services for all architect and appraisal fees