

		FOR BHF USE					

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2008
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2008)

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

<p>I. IDPH License ID Number: <u>0034991</u></p> <p>Facility Name: <u>PARK HOUSE</u></p> <p>Address: <u>2320 SOUTH LAWNDALE</u> <u>CHICAGO</u> <u>60623</u> Number City Zip Code</p> <p>County: <u>COOK</u></p> <p>Telephone Number: <u>(847) 329-1555</u> Fax # <u>(847) 329-9555</u></p> <p>HFS ID Number: <u>36-3620976</u></p> <p>Date of Initial License for Current Owners: <u>1-1-89</u></p> <p>Type of Ownership:</p> <table border="0"> <tr> <td><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input checked="" type="checkbox"/> PROPRIETARY</td> <td><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td>IRS Exemption Code _____</td> <td><input type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input checked="" type="checkbox"/> "Sub-S" Corp.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Limited Liability Co.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other _____</td> <td></td> </tr> </table>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County	IRS Exemption Code _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input checked="" type="checkbox"/> "Sub-S" Corp.			<input type="checkbox"/> Limited Liability Co.			<input type="checkbox"/> Trust			<input type="checkbox"/> Other _____		<p>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/2008</u> to <u>12/31/2008</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="1"> <tr> <td rowspan="2">Officer or Administrator of Provider</td> <td>(Signed) _____</td> <td>(Date) _____</td> </tr> <tr> <td>(Type or Print Name) <u>SHERWIN I. RAY</u></td> <td></td> </tr> <tr> <td></td> <td>(Title) <u>PRESIDENT</u></td> <td></td> </tr> <tr> <td rowspan="4">Paid Preparer</td> <td>(Signed) <u>(SEE ATTACHED ACCOUNTANTS' REPORT)</u></td> <td>(Date) _____</td> </tr> <tr> <td>(Print Name and Title) <u>BOB KAGDA</u> <u>VICE PRESIDENT</u></td> <td></td> </tr> <tr> <td>(Firm Name & Address) <u>KRUPNICK, BOKOR, KAGDA & BROOKS, LTD</u> <u>3750 W DEVON, LINCOLNWOOD, IL 60712-1124</u></td> <td></td> </tr> <tr> <td>(Telephone) <u>(847) 675-3585</u> Fax # <u>(847) 675-5777</u></td> <td></td> </tr> </table>	Officer or Administrator of Provider	(Signed) _____	(Date) _____	(Type or Print Name) <u>SHERWIN I. RAY</u>			(Title) <u>PRESIDENT</u>		Paid Preparer	(Signed) <u>(SEE ATTACHED ACCOUNTANTS' REPORT)</u>	(Date) _____	(Print Name and Title) <u>BOB KAGDA</u> <u>VICE PRESIDENT</u>		(Firm Name & Address) <u>KRUPNICK, BOKOR, KAGDA & BROOKS, LTD</u> <u>3750 W DEVON, LINCOLNWOOD, IL 60712-1124</u>		(Telephone) <u>(847) 675-3585</u> Fax # <u>(847) 675-5777</u>	
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<p>In the event there are further questions about this report, please contact: Name: <u>BOB KAGDA</u> Telephone Number: <u>(847) 675-3585</u> Email Address: _____</p>	<p>MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630</p>																																									

Facility Name & ID Number PARK HOUSE

0034991 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	14	Skilled (SNF)	14	5,124	1
2		Skilled Pediatric (SNF/PED)			2
3	92	Intermediate (ICF)	92	33,672	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	106	TOTALS	106	38,796	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			865	865	8
9	SNF/PED					9
10	ICF	32,946	535		33,481	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	32,946	535	865	34,346	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 88.53%

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 1/1/89

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

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified _____ and days of care provided 865

Medicare Intermediary ADMINISTAR

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 **PARK HOUSE** # **0034991** 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	175,772	21,269	6,356	203,397		203,397		203,397		1
2	Food Purchase		169,200		169,200		169,200	(1,506)	167,694		2
3	Housekeeping	143,070	37,923		180,993		180,993		180,993		3
4	Laundry	40,884	15,235		56,119		56,119		56,119		4
5	Heat and Other Utilities			78,090	78,090		78,090	68	78,158		5
6	Maintenance	32,599	29,994	42,590	105,183		105,183	11,615	116,798		6
7	Other (specify):*			19,561	19,561		19,561	28	19,589		7
8	TOTAL General Services	392,325	273,621	146,597	812,543		812,543	10,205	822,748		8
	B. Health Care and Programs										
9	Medical Director			32,500	32,500		32,500		32,500		9
10	Nursing and Medical Records	1,347,264	53,895	4,736	1,405,895		1,405,895	26,020	1,431,915		10
10a	Therapy	70,204	1,603	11,160	82,967		82,967	4,281	87,248		10a
11	Activities	74,702	22,412	4,252	101,366		101,366		101,366		11
12	Social Services	112,475			112,475		112,475		112,475		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,604,645	77,910	52,648	1,735,203		1,735,203	30,301	1,765,504		16
	C. General Administration										
17	Administrative	60,711		102,000	162,711		162,711	(17,963)	144,748		17
18	Directors Fees										18
19	Professional Services			133,039	133,039		133,039	(51,531)	81,508		19
20	Dues, Fees, Subscriptions & Promotions			18,825	18,825		18,825	1,420	20,245		20
21	Clerical & General Office Expenses	34,628	15,163	98,031	147,822		147,822	18,892	166,714		21
22	Employee Benefits & Payroll Taxes			360,146	360,146		360,146		360,146		22
23	Inservice Training & Education			2,893	2,893		2,893	1,530	4,423		23
24	Travel and Seminar							56	56		24
25	Other Admin. Staff Transportation			3,971	3,971		3,971	9,115	13,086		25
26	Insurance-Prop.Liab.Malpractice			54,107	54,107		54,107	1,758	55,865		26
27	Other (specify):*							39,699	39,699		27
28	TOTAL General Administration	95,339	15,163	773,012	883,514		883,514	2,976	886,490		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,092,309	366,694	972,257	3,431,260		3,431,260	43,482	3,474,742		29

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

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

V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE	SCHED REF	TOTAL
1	DIETARY	
	DIETITIAN CONSULTANT XVIII B 35-2	6,356
	REPAIRS & MAINTENANCE	0
		0
		6,356
3	HOUSEKEEPING	
		0
		0
		0
4	LAUNDRY	
	EQUIPMENT REPAIRS & MAINTENANCE	0
		0
		0
5	HEAT & OTHER UTILITIES	
	GAS HEAT	27,870
	ELECTRICITY	40,934
	WATER	5,616
	CABLE TV - LOBBY	3,670
		0
		78,090
6	MAINTENANCE	
	GROUNDS MAINTENANCE	11,911
	PAINTING & DECORATING	0
	BUILDING REPAIRS	0
	MAINTENANCE TRAVEL	0
	EQUIPMENT MAINTENANCE & REPAIR	15,255
	ELEVATOR MAINTENANCE & REPAIR	4,113
	OUTSIDE LABOR	0
	EXTERMINATING SERVICE	3,779
	FIRE SERVICE	7,532
		0
		0
		0
		0
		42,590
7	OTHER	
	SCAVENGER	19,378
	SECURITY SERVICE	183
		0
		0
		19,561
9	MEDICAL DIRECTOR	
	MEDICAL DIRECTOR FEES XVIII B 36-2	32,500
		32,500

LINE	SCHED REF	TOTAL
10	NURSING	
	CONTRACT NURSING XVIII C 53-2	
	LABORATORY & XRAY EXPENSE	0
	PURCHASED SERVICES	2,364
	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	900
	UTILIZATION REVIEW FEES XVIII B ___-2	0
	PHYSICIANS XVIII B ___-2	0
	PSYCHIATRIC XVIII B ___-2	0
	RN CONSULTANT XVIII B 38-2	0
		0
		0
		4,736
10a	THERAPY	
	PHYSICAL THERAPY SERVICES	1,160
	SPEECH THERAPY SERVICES	40
	OCCUPATIONAL THERAPY SERVICES	60
	REHABILITATION CONSULTANT XVIII B ___-2	0
	PHYSICAL THERAPY CONSULTANT XVIII B 40-2	4,950
	OCCUPATIONAL THERAPY CONSULTA XVIII B 41-2	4,950
	RESPIRATORY THERAPY CONSULTAN XVIII B 42-2	0
	SPEECH THERAPY CONSULTANT XVIII B 43-2	0
		11,160
11	ACTIVITIES	
	CABLE TV - PATIENT ROOMS	
	ACTIVITY REHAB CONSULTANT XVIII B 44-2	4,252
		0
		4,252
12	SOCIAL SERVICES	
	SOCIAL REHABILITATION SERVICES	
	SOCIAL REHABILITATION CONSULTAN XVIII B 45-2	0
	SOCIAL WORKER XVIII B 45-2	0
		0
		0
13	NURSE AIDE TRAINING	
	NURSE AIDE TRAINING COSTS XIII	0
		0

V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE	SCHED REF	TOTAL
14	PROGRAM TRANSPORTATION	
	PATIENT TRANSPORTATION	0
17	ADMINISTRATIVE	
	MANAGEMENT FEES XIX B	102,000
	DIRECTORS FEES	
18	DIRECTORS FEES	0
19	PROFESSIONAL SERVICES	
	DATA PROCESSING XIX C	12,646
	ADMINISTRATIVE CONSULTANTS XIX C	63,600
	PROFESSIONAL FEES XIX C	56,793
		0
		133,039
20	FEES,SUBSCRIPTIONS,PROMOTIONS	
	ENTERTAINMENT & MARKETING VI 19 XIX F	0
	ADV & PROMO-NON PATIENT RELATED VI 25 XIX F	1,493
	EMPLOYEE WANT ADS XIX F	11,070
	CONTRIBUTIONS VI 20 XIX F	0
	DUES & SUBSCRIPTIONS XIX F	1,166
	LICENSES & PERMITS XIX F	5,096
	PUBLIC RELATIONS-PATIENT RELATED XIX F	0
	ADVERTISING-YELLOW PAGES VI 28 XIX F	0
	TRUST FEES / FRANCHISE TAX / ETC VI 17 XIX F	0
	CONTRIBUTIONS - POLITICAL VI 20 XIX F	0
	HEALTH CARE WORKER BACKGROUND CHEC XIX F	0
	PATIENT BACKGROUND CHECKS XIX F	0
		18,825
21	CLERICAL & GENERAL OFFICE EXPENSES	
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)	0
	EQUIPMENT REPAIR & MAINTENANCE	18,166
	OUTSIDE CLERICAL SERVICES	38,160
	PENALTIES / OVERDRAFT CHARGES VI 18	17,220
	HOME OFFICE EXPENSE	0
	THEFT & DAMAGE LOSS	356
	TELEPHONE	21,071
	MESSENGER SERVICE	3,058
		0
		98,031

LINE	SCHED REF	TOTAL
22	EMPLOYEE BENEFITS & PAYROLL TAXES	
	FICA TAXES XIX D	138,658
	UNEMPLOYMENT COMPENSATION XIX D	65,391
	WORKERS COMPENSATION INSURANC XIX D	57,164
	HOSPITALIZATION INSURANCE XIX D	90,583
	EMPLOYEE BENEFITS - OTHER XIX D	8,278
	EMPLOYEE PHYSICAL EXAMS XIX D	72
	INSURANCE - EXECUTIVE LIFE VI 21/XIX D	0
	PENSION/PROFIT SHARING PLANS XIX D	0
	CHICAGO HEAD TAX XIX D	0
		0
		360,146
23	INSERVICE TRAINING & EDUCATION	
	EDUCATION & SEMINARS	2,893
		2,893
24	TRAVEL & SEMINARS	
	EDUCATION & SEMINARS XIX G	0
	TRAVEL XIX G	0
		0
25	ADMIN. STAFF TRANSPORTATION	
	TRANSPORTATION - STAFF	3,971
		3,971
26	INSURANCE - PROP. LIAB & MALPRACTICE	
	GENERAL INSURANCE	54,107
		54,107
27	OTHER	
	BAD DEBTS VI 24	0
		0

GRAND TOTAL COLUMN 3 OTHER

972,257

**PARK HOUSE
SCHEDULES
12/31/2008**

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

TOTAL FOOD PURCHASE	169,200
LESS SALES TAX	<u>(1,506)</u>
NET FOOD	167,694

TOTAL PATIENT CENSUS	34,346
TIME 3 MEALS PER DAY	<u>3</u>
TOTAL PATIENT MEALS	103,038

ADD # EMPLOYEE MEALS/DAY	0
TIME # DAYS	<u>366</u>
TOTAL EMPLOYEE MEALS	0

PATIENT MEALS	103,038
ADD EMPLOYEE MEALS	<u>0</u>
TOTAL MEALS/YEAR	103,038

NET FOOD	167,694
DIVIDE TOTAL MEALS/YEAR	<u>103,038</u>

COST PER MEAL	1.63
TIME EMPLOYEE MEALS	<u>0</u>
EMPLOYEE MEAL RECLASSIFICATION	0

=====

Facility Name & ID Number **PARK HOUSE**

#0034991

Report Period Beginning:

01/01/2008

Ending:

12/31/2008

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			69,958	69,958		69,958	24,079	94,037			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			9,953	9,953		9,953	349,980	359,933			32
33	Real Estate Taxes			70,493	70,493		70,493	5,742	76,235			33
34	Rent-Facility & Grounds			222,227	222,227		222,227	(222,227)				34
35	Rent-Equipment & Vehicles			18,694	18,694		18,694	6,350	25,044			35
36	Other (specify):* TAG-OFFICE			15,600	15,600		15,600	(15,600)				36
37	TOTAL Ownership			406,925	406,925		406,925	148,324	555,249			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		38,008	61,050	99,058		99,058		99,058			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			58,194	58,194		58,194		58,194			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		38,008	119,244	157,252		157,252		157,252			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,092,309	404,702	1,498,426	3,995,437		3,995,437	191,806	4,187,243			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	(23,750)	30		9
10	Interest and Other Investment Income	(18,780)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,506)	2		13
14	Non-Care Related Interest	(9,953)	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees		20		17
18	Fines and Penalties	(17,220)	21		18
19	Entertainment		20		19
20	Contributions		20		20
21	Owner or Key-Man Insurance		22		21
22	Special Legal Fees & Legal Retainers	(425)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt		27		24
25	Fund Raising, Advertising and Promotional	(1,493)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising		20		28
29	Other-Attach Schedule				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (73,127)		\$	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)	264,933		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 264,933		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ 191,806		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						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

PARK HOUSE

ID# 0034991

Report Period Beginning: 01/01/2008

Ending: 12/31/2008

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
1		\$	1
2			2
3			3
4			4
5			5
6			6
7			7
8			8
9			9
10			10
11			11
12			12
13			13
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29			29
30			30
31			31
32			32
33			33
34			34
35			35
36			36
37			37
38			38
39			39
40			40
41			41
42			42
43			43
44			44
45			45
46			46
47			47
48			48
49	Total	0	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number PARK HOUSE# 0034991

Report Period Beginning:

01/01/2008

Ending:

12/31/2008

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)	
1	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(1,506)	0	0	0	0	0	0	0	0	0	0	(1,506)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	68	0	0	0	0	0	0	0	68	5
6	Maintenance	0	0	0	11,615	0	0	0	0	0	0	0	11,615	6
7	Other (specify):*	0	0	0	28	0	0	0	0	0	0	0	28	7
8	TOTAL General Services	(1,506)	0	0	11,711	0	10,205	8						
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	26,020	0	0	0	0	0	0	0	26,020	10
10a	Therapy	0	0	0	4,281	0	0	0	0	0	0	0	4,281	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	0	0	30,301	0	30,301	16						
	C. General Administration													
17	Administrative	0	0	(102,000)	84,037	0	0	0	0	0	0	0	(17,963)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(425)	0	(63,600)	12,494	0	0	0	0	0	0	0	(51,531)	19
20	Fees, Subscriptions & Promotions	(1,493)	0	0	2,913	0	0	0	0	0	0	0	1,420	20
21	Clerical & General Office Expenses	(17,220)	0	(38,160)	74,272	0	0	0	0	0	0	0	18,892	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	1,530	0	0	0	0	0	0	0	1,530	23
24	Travel and Seminar	0	0	0	56	0	0	0	0	0	0	0	56	24
25	Other Admin. Staff Transportation	0	0	0	9,115	0	0	0	0	0	0	0	9,115	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	1,758	0	0	0	0	0	0	0	1,758	26
27	Other (specify):*	0	0	0	39,699	0	0	0	0	0	0	0	39,699	27
28	TOTAL General Administration	(19,138)	0	(203,760)	225,874	0	2,976	28						
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(20,644)	0	(203,760)	267,886	0	43,482	29						

STATE OF ILLINOIS

Summary B

Facility Name & ID Number PARK HOUSE# 0034991

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	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
30	Depreciation	(23,750)	41,008	0	6,821	0	0	0	0	0	0	0	24,079	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(28,733)	345,174	0	33,539	0	0	0	0	0	0	0	349,980	32
33	Real Estate Taxes	0	0	0	5,742	0	0	0	0	0	0	0	5,742	33
34	Rent-Facility & Grounds	0	(222,227)	0	0	0	0	0	0	0	0	0	(222,227)	34
35	Rent-Equipment & Vehicles	0	0	0	6,350	0	0	0	0	0	0	0	6,350	35
36	Other (specify):*	0	0	(15,600)	0	0	0	0	0	0	0	0	(15,600)	36
37	TOTAL Ownership	(52,483)	163,955	(15,600)	52,452	0	148,324	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)	(73,127)	163,955	(219,360)	320,338	0	191,806	45						

Facility Name & ID Number

PARK HOUSE

0034991

Report Period Beginning:

01/01/2008

Ending:

12/31/2008

VII. RELATED PARTIES

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

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

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	34 RENT	\$ 222,227	2320 S LAWNSDALE LLC	100.00%	\$	\$ (222,227)	1
2	V	30 SL DEPRECIATION		" "		38,397	38,397	2
3	V	32 INTEREST		" "		345,174	345,174	3
4	V							4
5	V							5
6	V	30 DEPRECIATION		CAREPLUS REHABILITATIVE SERVICES		2,611	2,611	6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 222,227			\$ 386,182	\$ * 163,955	14

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	17 MANAGEMENT FEE	\$ 102,000	CAREPLUS MGMT INC		\$	\$ (102,000) 15
16	V	19 ADMIN CONSULTANT	63,600	" "			(63,600) 16
17	V	19 DATA PROCESSING		" "			
18	V	21 CLERICAL FEES	38,160	" "			(38,160) 18
19	V	36 OFFICE RENT	15,600	" "			(15,600) 19
20	V			" "			
21	V						
22	V						
23	V						
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 219,360			\$ 0	\$ * (219,360) 39

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

Facility Name & ID Number PARK HOUSE# 0034991Report Period Beginning: 01/01/2008 Ending: 12/31/2008

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	5 UTILITIES	\$	CAREPLUS MGMT INC	100.00%	\$ 68	\$	68	15
16	V	6 MAINT & REPAIRS		" " "		6,802		6,802	16
17	V	6 MAINTENANCE SALARIES		" " "		4,813		4,813	17
18	V	7 SECURITY		" " "		28		28	18
19	V	10 NURSING SALARIES		" " "		26,020		26,020	19
20	V	10a THERAPY SALARIES		" " "		4,269		4,269	20
21	V	10a REHAB SUPPLIES		" " "		12		12	21
22	V	17 ADMIN SALARIES		" " "		84,037		84,037	22
23	V	19 PROFESSIONAL FEES		" " "		12,494		12,494	23
24	V	20 ADVERTISING		" " "		2,913		2,913	24
25	V	21 OFFICE EXPENSE		" " "		16,548		16,548	25
26	V	21 OFFICE SALARIES		" " "		57,724		57,724	26
27	V	23 SEMINARS		" " "		1,530		1,530	27
28	V	24 TRAVEL		" " "		56		56	28
29	V	25 TRANSPORTATION		" " "		9,115		9,115	29
30	V	26 INSURANCE		" " "		1,758		1,758	30
31	V	27 EMPLOYEE BENEFITS		" " "		39,699		39,699	31
32	V	30 DEPRECIATION		" " "		6,821		6,821	32
33	V	32 INTEREST		" " "		31,328		31,328	33
34	V	32 INTEREST-TAG 18 PPTY MTG		" " "		2,010		2,010	34
35	V	32 INTEREST-CP REHAB-EQ LOAN		" " "		201		201	35
36	V	33 REAL ESTATE TAX-TAG18 PPTY		" " "		5,742		5,742	36
37	V	35 EQUIPMENT RENT		" " "		6,350		6,350	37
38	V								38
39	Total		\$			\$ 320,338	\$ *	320,338	39

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

Facility Name & ID Number

PARK HOUSE

#

0034991

Report Period Beginning:

01/01/2008

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	JAKOB BAKST	DIR OPERATIONS			SEE ATTACHED			SALARY	17,912	17-7	2
3	SHERWIN I RAY	ADMIN CONSLT			SCHEDULE			SALARY	17,912	17-7	3
4	ROSLYN INDICH	CONTROLLER A/P						SALARY	5,584	17-7	4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 41,408		13

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

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

Facility Name & ID Number **PARK HOUSE**

0034991 Report Period Beginning: **01/01/2008** 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

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

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

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	373,906	10	\$ 739	\$ 34,346	\$ 68	1
2	6	MAINT & REPAIRS	PATIENT DAYS	373,906	10	74,048	34,346	6,802	2
3	6	MAINTENANCE SALARIES	PATIENT DAYS	373,906	10	52,396	52,396	4,813	3
4	7	SECURITY	PATIENT DAYS	373,906	10	308	34,346	28	4
5	10	NURSING SALARIES	PATIENT DAYS	373,906	10	283,260	283,260	26,020	5
6	10a	THERAPY SALARIES	PATIENT DAYS	373,906	10	46,472	46,472	4,269	6
7	10a	REHAB SUPPLIES	PATIENT DAYS	373,906	10	132	34,346	12	7
8	17	ADMIN SALARIES	PATIENT DAYS	373,906	10	914,862	914,862	84,037	8
9	19	PROFESSIONAL FEES	PATIENT DAYS	373,906	10	136,016	34,346	12,494	9
10	20	ADVERTISING	PATIENT DAYS	373,906	10	31,710	34,346	2,913	10
11	21	OFFICE EXPENSE	PATIENT DAYS	373,906	10	180,149	34,346	16,548	11
12	21	OFFICE SALARIES	PATIENT DAYS	373,906	10	628,409	628,409	57,724	12
13	23	SEMINARS	PATIENT DAYS	373,906	10	16,659	34,346	1,530	13
14	24	TRAVEL	PATIENT DAYS	373,906	10	612	34,346	56	14
15	25	TRANSPORATION	PATIENT DAYS	373,906	10	99,225	34,346	9,115	15
16	26	INSURANCE	PATIENT DAYS	373,906	10	19,140	34,346	1,758	16
17	27	EMPLOYEE BENEFITS	PATIENT DAYS	373,906	10	432,184	34,346	39,699	17
18	30	DEPRECIATION	PATIENT DAYS	373,906	10	74,261	34,346	6,821	18
19	32	INTEREST	PATIENT DAYS	373,906	10	341,048	34,346	31,328	19
20	32	INTEREST TAG 18	PATIENT DAYS	373,906	10	21,878	34,346	2,010	20
21	32	INTEREST CP REHAB EQUIP	PATIENT DAYS	373,906	10	2,189	34,346	201	21
22	33	REAL ESTATE TAX TAG 18	PATIENT DAYS	373,906	10	62,515	34,346	5,742	22
23	35	EQUIPMENT RENT	PATIENT DAYS	373,906	10	69,127	34,346	6,350	23
24									24
25	TOTALS					\$ 3,487,339	\$ 1,925,399	\$ 320,338	25

Facility Name & ID Number

PARK HOUSE

0034991

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**					Purpose of Loan	Monthly Payment Required					Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO											Original	Balance			
	A. Directly Facility Related																	
	Long-Term																	
1	RELATED PARTY:2320 S.LAWNDALE LLC						\$	\$			\$	1						
2	NOMURA		X	MORTGAGE				2,449,398				345,174	2					
3													3					
4													4					
5	RELATED PARTY	X										33,539	5					
	Working Capital																	
6													6					
7													7					
8													8					
9	TOTAL Facility Related						\$	\$ 2,449,398			\$	378,713	9					
	B. Non-Facility Related*																	
10	NON ALLOWABLE											9,953	10					
11													11					
12													12					
13													13					
14	TOTAL Non-Facility Related						\$	\$			\$	9,953	14					
15	TOTALS (line 9+line14)						\$	\$ 2,449,398			\$	388,666	15					

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

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

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

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

B. Real Estate Taxes

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

1. Real Estate Tax accrual used on 2007 report.		\$	74,000	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		\$	71,493	2
3. Under or (over) accrual (line 2 minus line 1).		\$	(2,507)	3
4. Real Estate Tax accrual used for 2008 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	73,000	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.		\$	70,493	7
Real Estate Tax History:				
Real Estate Tax Bill for Calendar Year:	2003	78,046	8	
	2004	79,779	9	
	2005	80,592	10	
	2006	72,265	11	
	2007	71,493	12	
THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED ON ~ 103% OF THE PRIOR YEAR REAL ESTATE TAX BILL				
	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

NOTES:

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

IMPORTANT NOTICE

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

FACILITY IDPH LICENSE NUMBER 0034991

CONTACT PERSON REGARDING THIS REPORT BOB KAGDA

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

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 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>16-26-105-075-0000</u>	<u>NURSING HOME</u>	\$ <u>31,163.71</u>	\$ <u>31,163.71</u>
2. <u>16-26-105-079-0000</u>	<u>NURSING HOME</u>	\$ <u>20,127.72</u>	\$ <u>20,127.72</u>
3. <u>16-26-105-080-0000</u>	<u>NURSING HOME</u>	\$ <u>20,201.98</u>	\$ <u>20,201.98</u>
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>71,493.41</u>	\$ <u>71,493.41</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 PARK HOUSE

0034991

Report Period Beginning:

01/01/2008 Ending:

12/31/2008

X. BUILDING AND GENERAL INFORMATION:

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

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

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

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

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

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

N/A

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

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs:

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

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1				\$	1
2					2
3	TOTALS			\$	3

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

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	106		1989		\$ 1,209,350	\$ 38,397	39	\$ 38,397	\$	\$ 766,331	4
5											5
6											6
7											7
8	RELATED PARTY					2,529		2,529			8
	Improvement Type**										
9	LEASEHOLD IMPROVEMENTS		1989		17,739	563	20	887	324	17,094	9
10	LEASEHOLD IMPROVEMENTS		1989		4,204		15			4,204	10
11	LEASEHOLD IMPROVEMENTS		1990		11,700	371	20	585	214	10,719	11
12	LEASEHOLD IMPROVEMENTS		1991		17,413	553	20	871	318	15,242	12
13	LEASEHOLD IMPROVEMENTS		1992		55,138	1,858	31.5	1,750	(108)	29,196	13
14	LEASEHOLD IMPROVEMENTS		1993		26,399	748	31.5	1,858	1,110	14,009	14
15	LEASEHOLD IMPROVEMENTS		1994		3,400	87	39	87		1,287	15
16	ROOF REPAIR		1995		1,500	38	39	38		515	16
17	ROOF-TOP HEAT/A/C		1996		10,000	256	39	256		3,297	17
18	CEILING TILE/DUMBWAITER REPAIR		1996		12,253	314	39	314		3,965	18
19											19
20	RE-ROOF		1996		80,861	2,073	39	2,073		25,565	20
21	FIXTURES/WINDOWS		1996		3,850	99	39	99		1,207	21
22	WINDOWS		1997		18,900	484	39	484		5,490	22
23	ROOF REPAIR & ROOF-TOP HEAT/A/C INSTALLATION		1997		3,228	83	39	83		952	23
24	DOOR & FLOORING		1997		2,922	75	39	75		866	24
25	ELEVATOR REPAIR		1997		3,125	80	39	80		910	25
26	WINDOWS		1998		12,600	323	39	323		3,473	26
27	TILE & FLOORING		1998		23,810	611	39	611		6,552	27
28	ELECTRICAL, PLUMBING AND ELEVATOR REPAIR		1998		31,238	801	39	801		8,519	28
29	NEW NURSE STATION		1998		24,271	622	39	622		6,765	29
30	WINDOW TREATMENTS AND BRAILLE SIGNS		1998		3,478	89	39	89		953	30
31	FIRE SYSTEM UPGRADE AND DAMPERS		1998		8,833	227	39	227		2,343	31
32	REAR PARKING LOT REPAIRS		1998		10,550	703	15	703		7,385	32
33	WINDOWS/CLOSETS/OUTLETS/DUMBWAITS/ROOF		1999		23,174	594	39	594		5,767	33
34	ROOF REPAIR		1999		18,365	471	39	471		4,494	34
35	FRONT RAMP REPAIR		2000		1,200	44	27.5	44		338	35
36	VINYL TILE/KITCHEN		2000		6,213	226	27.5	226		1,912	36

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

See Page 12A, Line 70 for total

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

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

Report Period Beginning:

01/01/2008 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	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	DUMBWAITER REPAIR	2001	\$ 3,264	\$ 119	27.5	\$ 119	\$	\$ 927	37
38	SIDEWALK/TUCKPOINTING	2001	5,500	367	15	367		2,752	38
39	KEYPAD ENTRY SYSTEM	2001	3,800	138	27.5	138		983	39
40	BOILER	2002	5,229	190	27.5	190		1,227	40
41	AC UNITS	2002	6,365	231	27.5	231		1,492	41
42	FLOORING	2002	2,328	85	27.5	85		46,485	42
43	FIRE PUMP REPAIR	2003	1,750	64	27.5	64		348	43
44	ELECTRICAL TO ROOFTOP UNIT	2003	1,951	71	27.5	71		388	44
45	PAINTING	2003	20,800	756	27.5	756		4,128	45
46	CEILING & DOOR REPAIR	2003	1,180	43	27.5	43		235	46
47	CONCRETE REPAIRS	2003	2,961	108	27.5	108		590	47
48	REBUILD NEW BATHROOMS	2004	7,478	272	27.5	272		1,213	48
49	WATER PUMP	2004	2,547	93	27.5	93		414	49
50	BOILER,BURNER,BACKSPLASH,GREASE TRAP/EXCAVATI	2005	8,945	325	27.5	325		1,128	50
51	WALL AC/CARPET	2005	14,131	514	27.5	514		1,779	51
52	ELEVATOR REPAIR/ ROOFTOP AC	2005	22,770	828	5	828		2,858	52
53	PAINTING	2006	13,760	2,642	15	2,642		9,797	53
54	LANDSCAPING & CEMENT WORK	2006	13,400	893	27.5	893		2,233	54
55	BATHROOM REMODEL	2006	3,800	138	27.5	138		339	55
56	EMERGENCY LIGHTS, ALARMS & LOCKS	2006	9,288	338		338		831	56
57									57
58									58
59	CARE PLUS REHAB:								59
60	WINDOWS	2004	11,385	292	39	292		1,253	60
61	FLOORING	2004	30,110	772	39	772		3,828	61
62	HEAT EXCHANGER FOOFTOP UNIT	2007	2,772	101	39	101		147	62
63	PAINTING BUILDING	2007	2,560	93	39	93		136	63
64	ELECTRICAL WORK	2007	9,020	328	39	328		478	64
65	SMOKE & EXHAUST FANS	2007	5,249	191	39	191		278	65
66	COMPRESSOR & CONDENSING UNIT	2007	3,949	144	39	144		210	66
67	WALL AC UNITS CEILING TILES	2007	2,319	84	39	84		123	67
68	CEMENT WORK	2007	2,100	76	39	76		111	68
69	FENCE & GATES	2007	5,341	194		194		283	69
70	TOTAL (lines 4 thru 69)		\$ 1,871,766	\$ 63,809		\$ 65,667	\$ 1,858	\$ 1,036,344	70

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

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 1,871,766	\$ 63,809		\$ 65,667	\$ 1,858	\$ 1,036,344	1
2	2008	14,059	256	27.5	256		256	2
3	2008	8,100	147	27.5	147		147	3
4	2008	3,231	59	27.5	59		59	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)	\$ 1,897,156	\$ 64,271		\$ 66,129	\$ 1,858	\$ 1,036,806	34

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

Facility Name & ID Number **PARK HOUSE**

0034991

Report Period Beginning:

01/01/2008

Ending:

12/31/2008

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	\$ 194,510	\$ 12,166	\$ 18,134	\$ 5,968	10 YRS	\$ 120,622	71
72	Current Year Purchases	57,412	34,447	2,871	(31,576)	10 YRS	2,871	72
73	Fully Depreciated Assets	146,119					146,119	73
74	RELATED PARTY		6,903	6,903				74
75	TOTALS	\$ 398,041	\$ 53,516	\$ 27,908	\$ (25,608)		\$ 269,612	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)	\$ 2,295,197	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 117,787	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 94,037	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (23,750)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,306,418	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: 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

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: \$ 18,694 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			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	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	\$		\$ 34,317	\$		\$ 34,317	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			45			45	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			26,688			26,688	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				38,008		38,008	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):									13
14	TOTAL			\$		\$ 61,050	\$ 38,008		\$ 99,058	14

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

Facility Name & ID Number **PARK HOUSE**

0034991

Report Period Beginning: **01/01/2008**

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	\$ 26,541	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>99,987</u>)	1,576,841		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	11,966		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	1,454,348		8
9	Other(specify): <u>RE TAX ESCROW</u>	11,731		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 3,081,427	\$	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	486,565		15
16	Equipment, at Historical Cost	398,041		16
17	Accumulated Depreciation (book methods)	(481,126)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <u>REPL RESERVE</u>	188,613		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 592,093	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 3,673,520	\$	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 481,775	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	145,420		30
31	Accrued Taxes Payable (excluding real estate taxes)	18,107		31
32	Accrued Real Estate Taxes(Sch.IX-B)	73,000		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)	\$ 718,302	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	280,925		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 280,925	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 999,227	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 2,674,293	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 3,673,520	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 2,168,465	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 2,168,465	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	505,828	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)	\$ 505,828	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)	\$ 2,674,293	24 *

* This must agree with page 17, line 47.

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

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

1

	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 4,470,396	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,470,396	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	12,089	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 12,089	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***	18,780	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 18,780	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)	\$ 4,501,265	30

2

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	812,543	31
32	Health Care	1,735,203	32
33	General Administration	883,514	33
	B. Capital Expense		
34	Ownership	406,925	34
	C. Ancillary Expense		
35	Special Cost Centers	99,058	35
36	Provider Participation Fee	58,194	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 3,995,437	40
41	Income before Income Taxes (line 30 minus line 40)**	505,828	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 505,828	43

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

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

TAX RETURN PREPARED ON CASH BASIS

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

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

Facility Name & ID Number **PARK HOUSE**

0034991

Report Period Beginning:

01/01/2008

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	2,006	2,163	\$ 74,082	\$ 34.25	1
2	Assistant Director of Nursing	1,680	2,903	51,901	17.88	2
3	Registered Nurses	2,015	2,157	88,617	41.08	3
4	Licensed Practical Nurses			339,238		4
5	CNAs & Orderlies	41,025	45,852	472,772	10.31	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	5,901	6,325	70,204	11.10	8
9	Activity Director					9
10	Activity Assistants	7,400	8,157	74,702	9.16	10
11	Social Service Workers	5,600	6,378	112,475	17.63	11
12	Dietician					12
13	Food Service Supervisor	2,067	2,281	39,590	17.36	13
14	Head Cook	4,011	4,571	36,759	8.04	14
15	Cook Helpers/Assistants	9,410	10,556	99,423	9.42	15
16	Dishwashers					16
17	Maintenance Workers	2,082	2,240	32,599	14.55	17
18	Housekeepers	13,813	15,174	143,070	9.43	18
19	Laundry	4,042	4,371	40,884	9.35	19
20	Administrator	2,064	2,174	60,711	27.93	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	1,851	2,009	34,628	17.24	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	1,825	1,942	20,796	10.71	31
32	Other Health Care(specify)	14,930	16,118	299,858	18.60	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	121,722	135,371	\$ 2,092,309 *	\$ 15.46	34

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

** See instructions.

B. CONSULTANT SERVICES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference		
35	Dietary Consultant	M	\$ 6,356	1-3	35
36	Medical Director	O	32,500	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	900	10-3	39
40	Physical Therapy Consultant	L	4,950	10a-3	40
41	Occupational Therapy Consultant	Y	4,950	10a-3	41
42	Respiratory Therapy Consultant		0	10a-3	42
43	Speech Therapy Consultant	F	0	10a-3	43
44	Activity Consultant	E	4,252	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)		\$ 55,380		49

C. CONTRACT NURSES

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

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
YECHIEL MASHIACH	ADMINISTRATOR		\$ 57,466	Workers' Compensation Insurance	\$ 57,164	IDPH License Fee	\$	
EDUARDO TORRES	ADMINISTRATOR		3,245	Unemployment Compensation Insurance	65,391	Advertising: Employee Recruitment	11,070	
				FICA Taxes	138,658	Health Care Worker Background Check	0	
				Employee Health Insurance	90,583	(Indicate # of checks performed)		
				Employee Meals	0	Patient Background Checks	0	
				Illinois Municipal Retirement Fund (IMRF)*		TRUST/FRANCHISE/CONTRIB/ETC	0	
				EMPLOYEE BENEFITS - OTHER	8,278	MARKETING/ADV/PROMO	1,493	
				EMPLOYEE PHYSICAL EXAMS	72	LICENSES/DUES/SUBSCRIPTIONS	6,262	
						MGMT CO ALLOC	2,913	
						TRUST/FRANCHISE/CONTRIB/ETC	0	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 60,711			Less: Public Relations Expense	(0)	
B. Administrative - Other						Non-allowable advertising	(1,493)	
Description			Amount			Yellow page advertising	(0)	
			\$ 102,000					
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 102,000	TOTAL (agree to Schedule V, line 22, col.8)	\$ 360,146	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 20,245	
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount
			\$			\$	Out-of-State Travel	\$
							In-State Travel	
								0
							MGMT CO ALLOC	56
							Seminar Expense	
								0
							Entertainment Expense	()
							(agree to Sch. V, line 24, col. 8)	
SEE SCHEDULE ATTACHED			133,039	TOTAL		\$	TOTAL	\$ 56
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 133,039					

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number PARK HOUSE# 0034991Report Period Beginning: 01/01/2008Ending: 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? NO
If YES, give association name and amount. _____
- (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. \$ 269 Line 10-2
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? NO
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? _____ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 58,194
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? NO If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? YES
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? NO For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? N/A Indicate the amount. \$ _____
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? NO
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? 5%
d. Have vehicle usage logs been maintained? NO
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? NO
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? YES
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? NO
Firm Name: _____ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? _____ If no, please explain. _____
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? YES
- (19) If total legal fees are in excess of \$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