

		FOR BHF USE					

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2009
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2009)

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>0044602</u></p> <p>Facility Name: <u>OAK PARK HEALTHCARE CENTER</u></p> <p>Address: <u>625 NORTH HARLEM</u> <u>OAK PARK</u> <u>60302</u> Number City Zip Code</p> <p>County: <u>COOK</u></p> <p>Telephone Number: <u>(847) 905-3000</u> Fax # <u>(847) 491-9565</u></p> <p>HFS ID Number: <u>36-4303161</u></p> <p>Date of Initial License for Current Owners: <u>11/01/99</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 type="checkbox"/> "Sub-S" Corp.</td> <td></td> </tr> <tr> <td></td> <td><input checked="" type="checkbox"/> Limited Liability Co.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other _____</td> <td></td> </tr> </table> <p>In the event there are further questions about this report, please contact: Name: <u>BOB KAGDA</u> Telephone Number: <u>(847) 675-3585</u> Email Address: _____</p>	<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 type="checkbox"/> "Sub-S" Corp.			<input checked="" 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>01/01/2009</u> to <u>12/31/2009</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="1"> <tr> <td rowspan="2" style="width: 15%;">Officer or Administrator of Provider</td> <td>(Signed) _____</td> </tr> <tr> <td>(Date) _____</td> </tr> <tr> <td></td> <td>(Type or Print Name) _____</td> </tr> <tr> <td></td> <td>(Title) _____</td> </tr> <tr> <td rowspan="4" style="width: 15%;">Paid Preparer</td> <td>(Signed) (SEE ATTACHED ACCOUNTANTS' REPORT) _____</td> </tr> <tr> <td>(Date) _____</td> </tr> <tr> <td>(Print Name and Title) <u>BOB KAGDA</u> <u>VICE PRESIDENT</u></td> </tr> <tr> <td>(Firm Name & Address) <u>KRUPNICK, BOKOR, KAGDA & BROOKS, LTD</u> <u>3750 W DEVON, LINCOLNWOOD, IL 60712-1124</u></td> </tr> <tr> <td></td> <td>(Telephone) <u>(847) 675-3585</u> Fax # <u>(847) 675-5777</u></td> </tr> </table> <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>	Officer or Administrator of Provider	(Signed) _____	(Date) _____		(Type or Print Name) _____		(Title) _____	Paid Preparer	(Signed) (SEE ATTACHED ACCOUNTANTS' REPORT) _____	(Date) _____	(Print Name and Title) <u>BOB KAGDA</u> <u>VICE PRESIDENT</u>	(Firm Name & Address) <u>KRUPNICK, BOKOR, KAGDA & BROOKS, LTD</u> <u>3750 W DEVON, LINCOLNWOOD, IL 60712-1124</u>		(Telephone) <u>(847) 675-3585</u> Fax # <u>(847) 675-5777</u>
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Facility Name & ID Number OAK PARK HEALTHCARE CENTER

0044602 Report Period Beginning: 01/01/2009 Ending: 12/31/2009

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	204	Skilled (SNF)	204	74,460	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	204	TOTALS	204	74,460	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment				5
		3 Medicaid Recipient	3 Private Pay	4 Other	4 Total	
8	SNF			5,127	5,127	8
9	SNF/PED					9
10	ICF	50,023	352		50,375	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	50,023	352	5,127	55,502	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 74.54%

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 5,127

Medicare Intermediary ADMINASTAR

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/2009 Fiscal Year: 12/31/09

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

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	194,989	32,572	15,358	242,919		242,919	242,919		1	
2	Food Purchase		224,963		224,963	(13,907)	211,056	210,829		2	
3	Housekeeping	177,560	44,233		221,793		221,793	221,793		3	
4	Laundry	49,987	13,676		63,663		63,663	63,663		4	
5	Heat and Other Utilities			198,313	198,313		198,313	198,313		5	
6	Maintenance	17,316	31,667	40,559	89,542		89,542	106,500		6	
7	Other (specify):*			26,942	26,942		26,942	27,057		7	
8	TOTAL General Services	439,852	347,111	281,172	1,068,135	(13,907)	1,054,228	1,071,074		8	
	B. Health Care and Programs										
9	Medical Director			6,000	6,000		6,000	6,000		9	
10	Nursing and Medical Records	2,287,106	151,511	3,204	2,441,821		2,441,821	2,472,075		10	
10a	Therapy	81,371	6,459	39,037	126,867		126,867	134,477		10a	
11	Activities	104,012	5,364	2,288	111,664		111,664	111,664		11	
12	Social Services	66,506			66,506		66,506	66,506		12	
13	CNA Training									13	
14	Program Transportation									14	
15	Other (specify):*									15	
16	TOTAL Health Care and Programs	2,538,995	163,334	50,529	2,752,858		2,752,858	2,790,722		16	
	C. General Administration										
17	Administrative	159,294		60,000	219,294		219,294	290,379		17	
18	Directors Fees									18	
19	Professional Services			311,043	311,043		311,043	84,455		19	
20	Dues, Fees, Subscriptions & Promotions			66,313	66,313		66,313	30,236		20	
21	Clerical & General Office Expenses	60,419	22,587	218,899	301,905		301,905	227,204		21	
22	Employee Benefits & Payroll Taxes			507,466	507,466	13,907	521,373	521,373		22	
23	Inservice Training & Education			4,776	4,776		4,776	6,063		23	
24	Travel and Seminar			188	188		188	447		24	
25	Other Admin. Staff Transportation			1,486	1,486		1,486	14,725		25	
26	Insurance-Prop.Liab.Malpractice			133,985	133,985		133,985	135,923		26	
27	Other (specify):* MARKETING	48,595		24,000	72,595		72,595	58,001		27	
28	TOTAL General Administration	268,308	22,587	1,328,156	1,619,051	13,907	1,632,958	1,368,806		28	
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,247,155	533,032	1,659,857	5,440,044		5,440,044	5,230,602		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	14,980
	REPAIRS & MAINTENANCE	378
		0
		15,358
3	HOUSEKEEPING	
		0
		0
		0
4	LAUNDRY	
	EQUIPMENT REPAIRS & MAINTENANCE	0
		0
		0
5	HEAT & OTHER UTILITIES	
	GAS HEAT	68,938
	ELECTRICITY	74,366
	WATER	54,165
	CABLE TV - LOBBY	844
		0
		198,313
6	MAINTENANCE	
	GROUNDS MAINTENANCE	1,830
	PAINTING & DECORATING	0
	BUILDING REPAIRS	4,110
	MAINTENANCE TRAVEL	0
	EQUIPMENT MAINTENANCE & REPAIR	18,175
	ELEVATOR MAINTENANCE & REPAIR	9,877
	OUTSIDE LABOR	0
	EXTERMINATING SERVICE	3,484
	FIRE SERVICE	3,083
		0
		0
		0
		0
		40,559
7	OTHER	
	SCAVENGER	26,900
	SECURITY SERVICE	42
		0
		0
		26,942
9	MEDICAL DIRECTOR	
	MEDICAL DIRECTOR FEES XVIII B 36-2	6,000
		6,000

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	0
	PHARMACY CONSULTANT XVIII B 39-2	3,204
	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
		3,204
10a	THERAPY	
	PHYSICAL THERAPY SERVICES	4,686
	SPEECH THERAPY SERVICES	628
	OCCUPATIONAL THERAPY SERVICES	5,594
	REHABILITATION CONSULTANT XVIII B __-2	0
	PHYSICAL THERAPY CONSULTANT XVIII B 40-2	0
	OCCUPATIONAL THERAPY CONSULTA XVIII B 41-2	0
	RESPIRATORY THERAPY CONSULTAN XVIII B 42-2	0
	SPEECH THERAPY CONSULTANT XVIII B 43-2	0
	THERAPY CONTRACT SERVICES	28,129
		39,037
11	ACTIVITIES	
	CABLE TV - PATIENT ROOMS	
	ACTIVITY REHAB CONSULTANT XVIII B 44-2	2,288
		0
		2,288
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
		0
17	ADMINISTRATIVE	
	MANAGEMENT FEES XIX B	60,000
		60,000
	DIRECTORS FEES	
18	DIRECTORS FEES	0
		0
19	PROFESSIONAL SERVICES	
	DATA PROCESSING XIX C	49,274
	ADMINISTRATIVE CONSULTANTS XIX C	205,000
	PROFESSIONAL FEES XIX C	56,769
		0
		311,043
20	FEES,SUBSCRIPTIONS,PROMOTIONS	
	ENTERTAINMENT & MARKETING VI 19 XIX F	0
	ADV & PROMO-NON PATIENT RELATED VI 25 XIX F	37,766
	EMPLOYEE WANT ADS XIX F	23,013
	CONTRIBUTIONS VI 20 XIX F	0
	DUES & SUBSCRIPTIONS XIX F	2,000
	LICENSES & PERMITS XIX F	2,856
	PUBLIC RELATIONS-PATIENT RELATED XIX F	0
	ADVERTISING-YELLOW PAGES VI 28 XIX F	296
	TRUST FEES / FRANCHISE TAX / ETC VI 17 XIX F	250
	CONTRIBUTIONS - POLITICAL VI 20 XIX F	0
	HEALTH CARE WORKER BACKGROUND CHEC XIX F	82
	PATIENT BACKGROUND CHECKS XIX F	50
		66,313
21	CLERICAL & GENERAL OFFICE EXPENSES	
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)	21
	EQUIPMENT REPAIR & MAINTENANCE	10,582
	OUTSIDE CLERICAL SERVICES	109,167
	PENALTIES / OVERDRAFT CHARGES VI 18	10,159
	HOME OFFICE EXPENSE	63,498
	THEFT & DAMAGE LOSS	471
	TELEPHONE	21,703
	MESSENGER SERVICE	3,298
		0
		218,899

LINE	SCHED REF	TOTAL
22	EMPLOYEE BENEFITS & PAYROLL TAXES	
	FICA TAXES XIX D	247,871
	UNEMPLOYMENT COMPENSATION XIX D	37,065
	WORKERS COMPENSATION INSURANC XIX D	83,246
	HOSPITALIZATION INSURANCE XIX D	108,602
	EMPLOYEE BENEFITS - OTHER XIX D	430
	EMPLOYEE PHYSICAL EXAMS XIX D	285
	INSURANCE - EXECUTIVE LIFE VI 21/XIX D	0
	PENSION/PROFIT SHARING PLANS XIX D	29,967
	CHICAGO HEAD TAX XIX D	0
		0
		507,466
23	INSERVICE TRAINING & EDUCATION	
	EDUCATION & SEMINARS	4,776
		4,776
24	TRAVEL & SEMINARS	
	EDUCATION & SEMINARS XIX G	0
	TRAVEL XIX G	188
		188
25	ADMIN. STAFF TRANSPORTATION	
	TRANSPORTATION - STAFF	1,486
		1,486
26	INSURANCE - PROP. LIAB & MALPRACTICE	
	GENERAL INSURANCE	131,523
	GENERAL INSURANCE EXPENSE	2,462
		133,985
27	OTHER	
	BAD DEBTS VI 24	24,000
		24,000

GRAND TOTAL COLUMN 3 OTHER **1,659,857**

**OAK PARK HEALTHCARE CENTER
SCHEDULES
12/31/2009**

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

TOTAL FOOD PURCHASE	224,963
LESS SALES TAX	(227)
NET FOOD	<u>224,736</u>
TOTAL PATIENT CENSUS	55,502
TIME 3 MEALS PER DAY	<u>3</u>
TOTAL PATIENT MEALS	<u>166,506</u>
ADD # EMPLOYEE MEALS/DAY	<u>30</u>
TIME # DAYS	<u>365</u>
TOTAL EMPLOYEE MEALS	<u>10,950</u>
PATIENT MEALS	166,506
ADD EMPLOYEE MEALS	<u>10,950</u>
TOTAL MEALS/YEAR	<u>177,456</u>
NET FOOD	224,736
DIVIDE TOTAL MEALS/YEAR	<u>177,456</u>
COST PER MEAL	1.27
TIME EMPLOYEE MEALS	<u>10,950</u>
EMPLOYEE MEAL RECLASSIFICATION	<u>13,907</u>
	=====

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

CAREPLUS MGT	31,640
ACHIEVE HEALTHCARE	1,602
AMERICAN DATA	5,950
NATIONAL DATA CARE	712
e-HEALTH DATA SOLUTIONS	3,685
ADAPTASOFT	424
OMNICARE	2,700
EMDEON	350
NEBO SYSTEMS	56
IVANS	56
BATCH PROCESSING	2,099
CAREPLUS MGT	165,000
EXTENDED CARE CONSULTING	40,000
KRUPNICK, BOKOR	9,200
MEYER MAGENCE	8,388
HON.STUART NUDELMAN	458
FINKEL MARTWICK	13,749
DR.KENNETH BROWNING	1,000
DERRICK FITTS	12,500
CHIZEK CONSULTING	5,720
CORP SVC CO	341
FIRST REAL ESTATE SERVICE	1,500
PERSONNEL PLANNER	3,553
HONKAMP KRUEGER	360
TOTAL PROFESSIONAL FEES	311,043
	=====

**EDUCATION AND SEMINARS
PAGE 3 LINE 23 COLUMN 3 OTHER**

<u>DATE</u>	<u>SPONSOR OF SEMINAR</u>
JAN	CRISIS PREVENTION
FEB	ICLTC
MAY	UNIVERSITY OF FLORIDA
JUN	MAYFIELD HEALTH CARE
JUL	PATHWAY HEALTH SERVICES
JUL	ICLTC
AUG	PATHWAY HEALTH SERVICES
DEC	COASTAL TRAINING TECH
DEC	FAMILY HEALTH MEDIA

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

KCI USA	NURSING EQUIPMENT	2,593
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INTEGRA HEALTHCARE	NURSING EQUIPMENT	8452
RCS MGMT	NURSING EQUIPMENT	265
ACCENT NURSING	NURSING EQUIPMENT	1274
JOHNSON WATER CONDITION	PLANT EQUIPMENT	240
MEIKEM	PLANT EQUIPMENT	2,145
AIR-SAVER	SMOKEETERS	2,125
FAMILY PRIDE	WASHER/DRYER	11,869
GE CAPITAL	COPIER	6,892
NEOPOST	COPIER	689
U-HAUL	STORAGE	1,071

TOTAL EQUIPMENT RENTAL EXPENSE		37,615
		=====

SEMINAR PURPOSE	EMPLOYEE	LOC	COST
CRISIS PREVENTION		IL	118.07
NEW OBRA PAIN REQUIREMENTS	K STAVROPOULOS, D PLEET	IL	435.00
	L PORTER		
DIETARY SUPERVISOR CERTIFICATION CLASS ONLINE STUDY	LEREATHA SMITH	IL	582.00
THE ALZHEIMER'S AND DEMENTIA SEMINAR	VALENCIA ROLLINS	IL	398.00
	MARILYN CINTRON		
RESTORATIVE/REHABILITATION CERTIFICATION COURSE	VIRGINIA HALL	IL	749.00
HEAR IT DIRECTLY FROM THE SURVEYORS: WHAT'S NEEDED; WHAT'S MISSING	GUS STAVROPOULOS	IL	190.00
	JUANITA PATRICK		
RESTORATIVE/REHABILITATION CERTIFICATION COURSE	VIRGINIA HALL	IL	749.00
10 ASSORTED DVD'S FOR INSERVICE TRAINING		IL	1509.36
PRESSURE ULCER PREVENTION DVD FOR INSERVICE TRAINING		IL	46.13

		TOTAL	4,776.56
			=====

Facility Name & ID Number

OAK PARK HEALTHCARE CENTER

#0044602

Report Period Beginning:

01/01/2009

Ending:

12/31/2009

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			76,739	76,739		76,739	5,638	82,377			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			382,403	382,403		382,403	107,297	489,700			32
33	Real Estate Taxes			616,482	616,482		616,482	6,297	622,779			33
34	Rent-Facility & Grounds			679,856	679,856		679,856		679,856			34
35	Rent-Equipment & Vehicles			42,186	42,186		42,186	9,009	51,195			35
36	Other (specify):* OFFICE RENT			24,000	24,000		24,000	(24,000)				36
37	TOTAL Ownership			1,821,666	1,821,666		1,821,666	104,241	1,925,907			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		202,521	312,415	514,936		514,936		514,936			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			111,690	111,690		111,690		111,690			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		202,521	424,105	626,626		626,626		626,626			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,247,155	735,553	3,905,628	7,888,336		7,888,336	(105,201)	7,783,135			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	(6,547)	30		9
10	Interest and Other Investment Income	(3)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(227)	2		13
14	Non-Care Related Interest	(221)	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees	(250)	20		17
18	Fines and Penalties	(10,159)	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	(24,000)	27		24
25	Fund Raising, Advertising and Promotional	(37,766)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(296)	20		28
29	Other-Attach Schedule	(48,543)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (128,012)		\$	30

BHF USE ONLY						
48		49		50		51
						52

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	22,811		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 22,811		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B)	\$ (105,201)		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: 01/01/2009

Ending: 12/31/2009

Sch. V Line

NON-ALLOWABLE EXPENSES

Amount

Reference

1	MARKETING SALARIES	\$ -48543	27	1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32

33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total		(48,543)	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number OAK PARK HEALTHCARE CENTER# 0044602

Report Period Beginning:

01/01/2009

Ending:

12/31/2009

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(227)	0	0	0	0	0	0	0	0	0	0	(227)	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	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	16,953	5	0	0	0	0	0	0	0	0	16,958	6
7	Other (specify):*	0	115	0	0	0	0	0	0	0	0	0	115	7
8	TOTAL General Services	(227)	17,068	5	0	16,846	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	30,254	0	0	0	0	0	0	0	0	0	30,254	10
10a	Therapy	0	7,610	0	0	0	0	0	0	0	0	0	7,610	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	37,864	0	0	0	0	0	0	0	0	0	37,864	16
	C. General Administration													
17	Administrative	0	71,085	0	0	0	0	0	0	0	0	0	71,085	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	(186,588)	(40,000)	0	0	0	0	0	0	0	0	(226,588)	19
20	Fees, Subscriptions & Promotions	(38,312)	2,206	29	0	0	0	0	0	0	0	0	(36,077)	20
21	Clerical & General Office Expenses	(10,159)	(102,000)	37,458	0	0	0	0	0	0	0	0	(74,701)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	1,287	0	0	0	0	0	0	0	0	1,287	23
24	Travel and Seminar	0	0	259	0	0	0	0	0	0	0	0	259	24
25	Other Admin. Staff Transportation	0	0	13,239	0	0	0	0	0	0	0	0	13,239	25
26	Insurance-Prop.Liab.Malpractice	0	0	1,938	0	0	0	0	0	0	0	0	1,938	26
27	Other (specify):*	(72,543)	0	57,949	0	0	0	0	0	0	0	0	(14,594)	27
28	TOTAL General Administration	(121,014)	(215,297)	72,159	0	(264,152)	28							
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(121,241)	(160,365)	72,164	0	(209,442)	29							

STATE OF ILLINOIS

Summary B

Facility Name & ID Number OAK PARK HEALTHCARE CENTER# 0044602

Report Period Beginning:

01/01/2009 Ending:

12/31/2009

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

	Capital Expense	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)	
	D. Ownership													
30	Depreciation	(6,547)	0	12,185	0	0	0	0	0	0	0	0	5,638	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(224)	0	107,521	0	0	0	0	0	0	0	0	107,297	32
33	Real Estate Taxes	0	0	6,297	0	0	0	0	0	0	0	0	6,297	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	9,009	0	0	0	0	0	0	0	0	9,009	35
36	Other (specify):*	0	(24,000)	0	0	0	0	0	0	0	0	0	(24,000)	36
37	TOTAL Ownership	(6,771)	(24,000)	135,012	0	104,241	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
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(128,012)	(184,365)	207,176	0	0	0	0	0	0	0	0	(105,201)	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	EVANSTON	MGMT/CLERICAL
				CAREPLUS REHABILITATIVE SERVICES		
SEE ATTACHED SCHEDULES					EVANSTON	THERAPY
				EXTENDED CARE CONSULTING		
					EVANSTON	MGMT/CLERICAL

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

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

1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	17 MANAGEMENT FEES	\$ 60,000	CAREPLUS MGMT INC		\$	\$ (60,000)	1
2	V	19 ADMIN. CONSULTANT FEES	165,000	" "			(165,000)	2
3	V	19 DATA PROCESSING FEES	31,640	" "			(31,640)	3
4	V	21 CLERICAL FEES	102,000	" "			(102,000)	4
5	V	36 OFFICE RENT	24,000	" "			(24,000)	5
6	V			" "				6
7	V	6 MAINTENANCE		" "		16,953	16,953	7
8	V	7 SECURITY		" "		115	115	8
9	V	10 NURSING		" "		30,254	30,254	9
10	V	10a THERAPY		" "		7,610	7,610	10
11	V	17 ADMIN		" "		131,085	131,085	11
12	V	19 PROFESSIONAL FEES		" "		10,052	10,052	12
13	V	20 DUES/LICENSES/WANT ADS		" "		2,206	2,206	13
14	Total		\$ 382,640			\$ 198,275	\$ * (184,365)	14

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

Facility Name & ID Number OAK PARK HEALTHCARE CENTER# 0044602Report Period Beginning: 01/01/2009 Ending: 12/31/2009

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		\$ 106,922	\$ 106,922
16	V	23 SEMINARS		" "		1,025	1,025
17	V	24 IN-STATE TRAVEL/LODGING		" "		250	250
18	V	25 TRANSPORTATION		" "		10,987	10,987
19	V	26 INSURANCE		" "		1,938	1,938
20	V	27 EMPLOYEE BENEFITS		" "		55,116	55,116
21	V	30 SL DEPRECIATION		" "		9,213	9,213
22	V	32 INTEREST		" "		107,521	107,521
23	V	33 REAL ESTATE TAX		" "		6,297	6,297
24	V	35 EQUIPMENT RENT		" "		9,009	9,009
25	V						
26	V	19 ADMINISTRATIVE CONSULTANT	40,000	EXTENDED CARE CONSULTING/CLINICAL			(40,000)
27	V	21 CLERICAL FEES	7,168	" "			(7,168)
28	V	21 HOME OFFICE EXPENSE	63,498	" "			(63,498)
29	V	6 MAINTENANCE & REPAIR		" "		5	5
30	V	20 DUES/LICENSES		" "		29	29
31	V	21 OFFICE EXPENSE		" "		1,202	1,202
32	V	23 SEMINARS		" "		262	262
33	V	24 TRAVEL		" "		9	9
34	V	25 TRANSPORTATION		" "		2,252	2,252
35	V	27 EMPLOYEE BENEFITS		" "		2,833	2,833
36	V						
37	V						
38	V	30 SL DEPRECIATION		CAREPLUS REHABILITATIVE SERVICES		2,972	2,972
39	Total		\$ 110,666			\$ 317,842	\$ * 207,176

* 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: 01/01/2009 Ending: 12/31/2009

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	2	3	4	5	6		7		8	9	
					Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**				
Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Hours	Percent	Description	Amount	Schedule V. Line & Column Reference		
1	CAREPLUS MGMT ALLOCATIONS:										
2	SHERWIN RAY	PRESIDENT	ADMIN/FINANCE	50.00	SEE ATTACHED	6.2	15.59	SALARY	30,400	17-7	2
3	JAKOB BAKST	DIR OPERAT'NS	ADMIN/CONS.	50.00	SCHEDULES	6.2	15.59	" "	30,400	17-7	3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 60,800		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: 01/01/2009

Ending: 2/31/2009

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 2201 MAIN ST
 City / State / Zip Code EVANSTON, IL 60202-1519
 Phone Number (847)905-3000
 Fax Number (847)491-9565

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	6	MAINTENANCE	CENSUS DAYS	8 FACILITIES	\$ 108,743	\$ 50,792	55,502	\$ 16,953	1
2	7	SECURITY	" "	8 FACILITIES	738		55,502	115	2
3	10	NURSING	" "	8 FACILITIES	194,059	194,059	55,502	30,254	3
4	10a	THERAPY	" "	8 FACILITIES	48,814	48,814	55,502	7,610	4
5	17	ADMIN SALARIES	" "	8 FACILITIES	840,831	840,831	55,502	131,085	5
6	19	PROFESSIONAL FEES	" "	8 FACILITIES	64,478		55,502	10,052	6
7	20	DUES/LICENSES/WANT ADS	" "	8 FACILITIES	14,148		55,502	2,206	7
8	21	OFFICE EXPENSES	" "	8 FACILITIES	685,841	547,685	55,502	106,922	8
9	23	SEMINARS	" "	8 FACILITIES	6,573		55,502	1,025	9
10	24	TRAVEL	" "	8 FACILITIES	1,601		55,502	250	10
11	25	TRANSPORTATION	" "	8 FACILITIES	70,475		55,502	10,987	11
12	26	INSURANCE	" "	8 FACILITIES	12,432		55,502	1,938	12
13	27	EMPLOYEE BENEFITS	" "	8 FACILITIES	353,538		55,502	55,116	13
14	30	SL DEPRECIATION	" "	8 FACILITIES	59,093		55,502	9,213	14
15	32	INTEREST-TAG MTG/LOC	" "	8 FACILITIES	689,687		55,502	107,521	15
16	33	REAL ESTATE TAX	" "	8 FACILITIES	40,394		55,502	6,297	16
17	35	EQUIP RENT/AUTO LEASE	" "	8 FACILITIES	57,785		55,502	9,009	17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 3,249,230	\$ 1,682,181		\$ 506,553	25

Facility Name & ID Number OAK PARK HEALTHCARE CENTER

0044602 Report Period Beginning: 01/01/2009

Ending: 2/31/2009

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 EXTENDED CARE CONSULTING
 Street Address 2201 MAIN ST
 City / State / Zip Code EVANSTON, IL 60202-1519
 Phone Number (847)905-3000
 Fax Number (847)491-9565

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	6	MAINTENANCE & REPAIR	CENSUS DAYS	58,508	8 FACILITIES	\$ 32	9,248	\$ 5	1
2	20	DUES/LICENSES	" "	58,508	8 FACILITIES	184	9,248	29	2
3	21	OFFICE EXPENSES	" "	58,508	8 FACILITIES	7,605	9,248	1,202	3
4	23	SEMINARS	" "	58,508	8 FACILITIES	1,657	9,248	262	4
5	24	TRAVEL	" "	58,508	8 FACILITIES	57	9,248	9	5
6	25	TRANSPORTATION	" "	58,508	8 FACILITIES	14,249	9,248	2,252	6
7	27	EMPLOYEE BENEFITS	" "	58,508	8 FACILITIES	17,921	9,248	2,833	7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 41,705	\$	\$ 6,592	25

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		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						\$	\$			\$ 107,521	1				
2												2				
3												3				
4												4				
5												5				
Working Capital																
6	CAREPLUS MGMT - HFG	X		WORKING CAPITAL	DEMAND	01/04	3,370,000	7,595,570	PRIME+		379,434	6				
7	INSURANCE FINANCING		X								2,748	7				
8												8				
9	TOTAL Facility Related						\$ 3,370,000	\$ 7,595,570			\$ 489,703	9				
B. Non-Facility Related*																
10	IRS, IDR, ETC		X	LATE FEES							221	10				
11												11				
12												12				
13												13				
14	TOTAL Non-Facility Related						\$	\$			\$ 221	14				
15	TOTALS (line 9+line14)						\$ 3,370,000	\$ 7,595,570			\$ 489,924	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

1. Real Estate Tax accrual used on 2008 report.	\$	383,170	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.)	\$	523,106	2
3. Under or (over) accrual (line 2 minus line 1).	\$	139,936	3
4. Real Estate Tax accrual used for 2009 report. (Detail and explain your calculation of this accrual on the lines below.)	\$	531,543	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 \$ 54,997 For 2005 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)	\$	(54,997)	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	\$	616,482	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2004	290,912	8
	2005	360,382	9
	2006	369,715	10
	2007	379,379	11
	2008	523,106	12

FOR BHF USE ONLY			
13	FROM R. E. TAX STATEMENT FOR 2008	\$	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 ~ 101.5% OF THE PRIOR YEAR REAL ESTATE TAX BILL
TOTAL 2009 ACCRUAL = OAK PARK HEALTHCARE 440,000 + OAK PARK CARE 91,543
THE PAYMENT ON LINE 2 APPLIES TO THE 2008 TAX BILL.

NOTES:

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

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2008 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 2008 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2008.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2008 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 2009 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.

2008 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 2008 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 2008.

	(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>104,456.94</u>	\$ <u>104,456.94</u>
2.	<u>16-07-106-005-0000</u>	<u>NURSING HOME</u>	\$ <u>101,284.04</u>	\$ <u>101,284.04</u>
3.	<u>16-07-106-022-0000</u>	<u>NURSING HOME</u>	\$ <u>317,364.60</u>	\$ <u>317,364.60</u>

4.	_____	_____	\$ _____	\$ _____
5.	_____	_____	\$ _____	\$ _____
6.	_____	_____	\$ _____	\$ _____
7.	_____	_____	\$ _____	\$ _____
8.	_____	_____	\$ _____	\$ _____
9.	_____	_____	\$ _____	\$ _____
10.	_____	_____	\$ _____	\$ _____
		TOTALS	\$ <u>523,105.58</u>	\$ <u>523,105.58</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 and 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 2008 tax bills which were listed in Section A to this statement. Be sure to use the 2008 tax bill which is normally paid during 2009.

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.**

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>		\$	1
2					2
3	TOTALS	22,950		\$	3

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9		
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4				\$	\$		\$	\$	\$	4
5										5
6										6
7										7
8										8
Improvement Type**										
9	NEW WINDOWS / LIGHT FIXTURES / GENERATOR	1999		74,653	1,914	39	1,914		19,235	9
10	WINDOWS / FENCE / CEILING	2000		13,360	486	27.5	486		4,840	10
11	WINDOWS / SIGNS / FLOORING / WALLPAPER	2000		42,672	1,552	27.5	1,552		15,299	11
12	WINDOWS / FLOORING / WALLPAPER / NURSE STATION	2000		29,709	1,080	27.5	1,080		10,485	12
13	FLOORING / DOORS / WALLS / HVAC SYSTEM	2000		56,310	2,047	27.5	2,047		19,703	13
14	WINDOWS / FLOORING / RAILS / ASPHALT PAVING	2000		30,160	1,096	27.5	1,096		10,418	14
15	WINDOWS / PLUMBING / PAINTING & DECORATING	2000		41,459	1,508	27.5	1,508		13,960	15
16	WINDOW TREATMENTS	2000		15,445		15	1,030	1,030	9,785	16
17	WINDOWS/WALK-IN FREEZER, ROOF & A/C REPAIRS	2001		23,850	868	27.5	868		7,536	17
18	WINDOWS/FLOORING/ALARM & PAGING SYSTEM	2001		9,926	361	27.5	361		2,926	18
19	WINDOWS/DOORS/GREASE TRAP/ROOF A/C	2002		62,212	2,266	27.5	2,266		17,001	19
20	WINDOWS/BACKFLOW PREVENTORS/AC TOWER BEARING	2003		16,526	603	27.5	603		4,076	20
21	CIRCUITS/ROOFTOP A/C MOTORS	2004		3,382	123	27.5	123		693	21
22	WINDOWS	2004		7,200	262	27.5	262		1,374	22
23	REMODEL MOLDINGS/HANDRAILS/CABINETS/DECOR	2004		68,233	2,480	27.5	2,480		13,069	23
24	LIGHTING/NSG STNS/BATHRMS/FLOORS/RAILS/MOLDINGS	2005		321,276	11,683	27.5	11,683		49,887	24
25	WINDOWS/DOORS/ROOF/SIDING/PORCH/PATIO	2005		164,807	5,993	27.5	5,993		26,019	25
26	LANDSCAPING	2005		16,610	1,108	15	1,108		4,985	26
27	ROOM SIGNS/HAND RAILS/LIGHTING/EXHAUST/TILE	2006		22,383	813	27.5	813		3,042	27
28	ROOFTOP A/C PUMP	2007		4,059	148	27.5	148		388	28
29	PARKING LOT PAVING / WINDOW TREATMENTS	2007		5,887	691	15	393	(298)	982	29
30	ELEVATOR POWER UNIT/ROOF EXHAUSTS/PIPES/KICKPLT	2008		20,387	742	27.5	742		1,192	30
31	REMODELING SHOWERS/DRYWALL/FLOORS	2008		108,483	3,944	27.5	3,944		5,424	31
32	CONCRETE	2008		1,600	107	15	107		160	32
33	DOORS/SIDELITES/ELECTRIC/ELEVATOR CAR SILL	2009		12,722	280	27.5	280		280	33
34										34
35										35
36										36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number OAK PARK HEALTHCARE CENTER

0044602

Report Period Beginning:

01/01/2009

Ending:

12/31/2009

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37								37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67								67
68								68
69								69
70								70
TOTAL (lines 4 thru 69)		\$ 1,234,832	\$ 46,049		\$ 46,781	\$ 732	\$ 243,391	

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

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 360,771	\$ 34,584	\$ 27,305	\$ (7,279)	8-15 YRS	\$ 137,214	71
72	Current Year Purchases							72
73	Fully Depreciated Assets							73
74	**REL'D PARTY-SL DEPN:CAREPL MGT, 5,425 /CP REHAB, 2,866		8,291	8,291				74
75	TOTALS	\$ 360,771	\$ 42,875	\$ 35,596	\$ (7,279)		\$ 137,214	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)	\$ 1,595,603	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 88,924	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 82,377	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (6,547)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 380,605	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:		<u>204</u>	<u>11/01/99</u>	\$ <u>679,856</u>			3
4	Additions							4
5								5
6								6
7	TOTAL		<u>204</u>		\$ <u>679,856</u>			7

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

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

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

12. _____ /2010 \$ _____

13. _____ /2011 \$ _____

14. _____ /2012 \$ _____

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: \$ 37,615 Description: SEE SCHEDULE ATTACHED

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	<u>ACTIVITY/HSKP/</u>	<u>2003 CHEVY EXPR 15P</u>	\$ _____	\$ <u>4,571</u>	17
18	<u>MAINT</u>				18
19					19
20					20
21	TOTAL		\$ _____	\$ <u>4,571</u>	21

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

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

Facility Name & ID Number OAK PARK HEALTHCARE CENTER # 0044602 Report Period Beginning: 01/01/2009 Ending: 12/31/2009
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><u>THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES</u></p>	<p>2. <u>CLASSROOM PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
---	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility			Total
		1	2	3	
		Drop-outs	Completed	Contract	
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	1 Schedule V Line & Column Reference	2 Staff		4 Outside Practitioner (other than consultant)		6 Supplies (Actual or Allocated)	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39-3	hrs	\$		\$ 44,237	\$		\$ 44,237	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			31,301			31,301	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			236,877			236,877	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescrpts				200,572		200,572	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					1,949		1,949	13
14	TOTAL			\$		\$ 312,415	\$ 202,521		\$ 514,936	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: **01/01/2009**

Ending:

12/31/2009**XV. BALANCE SHEET - Unrestricted Operating Fund.**As of **12/31/2009**

(last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance 115,000)	2,777,716		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	22,972		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): R.E.TAX ESCROW	107,539		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,908,227	\$	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	1,158,423		15
16	Equipment, at Historical Cost	375,659		16
17	Accumulated Depreciation (book methods)	(569,944)		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): DUE FROM NEW OPERATOR	500,343		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,464,481	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 4,372,708	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 1,565,022	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	13,130		28
29	Short-Term Notes Payable	7,595,570		29
30	Accrued Salaries Payable	46,119		30
31	Accrued Taxes Payable (excluding real estate taxes)	5,080		31
32	Accrued Real Estate Taxes(Sch.IX-B)	440,000		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)	\$ 9,664,921	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	380,362		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	DUE TO BUILDING LLC	71,170		43
44	MEMBER LOANS PAYABLE	1,330,000		44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 1,781,532	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 11,446,453	\$	46
47	TOTAL EQUITY (page 18, line 24)	\$ (7,073,745)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 4,372,708	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (6,970,855)	1
2	Restatements (describe):		2
3	POST-CLOSING ADDITIONAL BANK CHARGES	(3,757)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (6,974,612)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(137,444)	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) ADJ FOR OAK PARK CARE LLC	38,311	15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (99,133)	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)	\$ (7,073,745)	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	\$ 7,844,643	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 7,844,643	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen	6,888	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 6,888	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***	3	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 3	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 7,851,534	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	1,068,135	31
32	Health Care	2,752,858	32
33	General Administration	1,619,051	33
B. Capital Expense			
34	Ownership	1,821,666	34
C. Ancillary Expense			
35	Special Cost Centers	514,936	35
36	Provider Participation Fee	111,690	36
D. Other Expenses (specify):			
37	OUT-OF-PERIOD EXPENSES	100,642	37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 7,988,978	40
41	Income before Income Taxes (line 30 minus line 40)**	(137,444)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (137,444)	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: 01/01/2009

Ending:

12/31/2009

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	2,002	2,136	\$ 85,826	\$ 40.18	1
2	Assistant Director of Nursing	1,553	1,676	53,988	32.21	2
3	Registered Nurses	6,515	6,966	192,251	27.60	3
4	Licensed Practical Nurses	33,631	36,180	864,329	23.89	4
5	CNAs & Orderlies	77,502	85,599	917,624	10.72	5
6	CNA Trainees					6
7	Licensed Therapist	1,967	2,156	53,847	24.98	7
8	Rehab/Therapy Aides	2,080	2,373	27,524	11.60	8
9	Activity Director	1,950	2,061	32,974	16.00	9
10	Activity Assistants	6,337	6,985	71,038	10.17	10
11	Social Service Workers	3,670	3,892	66,506	17.09	11
12	Dietician					12
13	Food Service Supervisor	111	171	3,108	18.18	13
14	Head Cook	5,593	6,042	71,421	11.82	14
15	Cook Helpers/Assistants	11,113	12,034	120,460	10.01	15
16	Dishwashers					16
17	Maintenance Workers	1,305	1,443	17,316	12.00	17
18	Housekeepers	16,425	18,063	177,560	9.83	18
19	Laundry	3,869	4,354	49,987	11.48	19
20	Administrator	2,023	2,123	85,458	40.25	20
21	Assistant Administrator	2,021	2,259	73,836	32.69	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	5,446	6,070	60,419	9.95	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	2,085	2,185	23,232	10.63	31
32	Other Health C: MDS/CPC	5,620	6,071	149,856	24.68	32
33	Other(specify) <u>MARKETING</u>	1,956	2,052	48,595	23.68	33
34	TOTAL (lines 1 - 33)	194,774	212,891	\$ 3,247,155 *	\$ 15.25	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	\$ 14,980	1-3	35
36	Medical Director	O	6,000	9-3	36
37	Medical Records Consultant	N	0	10-3	37
38	Nurse Consultant	T	0	10-3	38
39	Pharmacist Consultant	H	3,204	10-3	39
40	Physical Therapy Consultant	L	0	10a-3	40
41	Occupational Therapy Consultant	Y	0	10a-3	41
42	Respiratory Therapy Consultant		0	10a-3	42
43	Speech Therapy Consultant	F	0	10a-3	43
44	Activity Consultant	E	2,288	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)		\$ 26,472		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

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

1	2	3	4	5	6	7	8	9	10	11	12	13
Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	FY2006	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014
1		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2												
3												
4												
5												
6												
7												
8												
9												
10												
11												
12												
13												
14												
15												
16												
17												
18												
19												
20	TOTALS	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

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. \$ 1,340 Line 10-2
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? NO
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? _____ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 111,690
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? NO If YES, attach an explanation of the allocation.

- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? YES
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? NO For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 13,907 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: _____
- (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.