

Facility Name & ID Number PARK HOUSE NURSING & REHAB CTR

0050740 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	14	Skilled (SNF)	14	5,110	1
2		Skilled Pediatric (SNF/PED)			2
3	92	Intermediate (ICF)	92	33,580	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	106	TOTALS	106	38,690	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF			1,213	1,213	8
9	SNF/PED					9
10	ICF	32,270	186		32,456	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	32,270	186	1,213	33,669	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 87.02%

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 11/01/2010

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

YES Date 11/01/2010 NO

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

YES NO If YES, enter number of beds certified _____ and days of care provided 1,213

Medicare Intermediary _____

IV. ACCOUNTING BASIS

ACCRAUAL 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.

Facility Name & ID Number

PARK HOUSE NURSING & REHAB CTR

0050740

Report Period Beginning:

01/01/2009

Ending:

12/31/2009

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	182,626	17,754	6,148	206,528		206,528		206,528		1
2	Food Purchase		167,998		167,998		167,998	(300)	167,698		2
3	Housekeeping	132,193	27,866		160,059		160,059		160,059		3
4	Laundry	39,878	15,273		55,151		55,151		55,151		4
5	Heat and Other Utilities			102,001	102,001		102,001		102,001		5
6	Maintenance	40,113	20,733	48,379	109,225		109,225	10,288	119,513		6
7	Other (specify):*			18,520	18,520		18,520	70	18,590		7
8	TOTAL General Services	394,810	249,624	175,048	819,482		819,482	10,058	829,540		8
	B. Health Care and Programs										
9	Medical Director			31,200	31,200		31,200		31,200		9
10	Nursing and Medical Records	1,258,098	60,557	10,199	1,328,854		1,328,854	18,353	1,347,207		10
10a	Therapy	82,044	2,538	14,108	98,690		98,690	4,616	103,306		10a
11	Activities	133,221	16,119	4,526	153,866		153,866		153,866		11
12	Social Services	64,715		7,996	72,711		72,711		72,711		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,538,078	79,214	68,029	1,685,321		1,685,321	22,969	1,708,290		16
	C. General Administration										
17	Administrative	62,294		85,000	147,294		147,294	(5,480)	141,814		17
18	Directors Fees										18
19	Professional Services			130,531	130,531		130,531	(94,599)	35,932		19
20	Dues, Fees, Subscriptions & Promotions			41,881	41,881		41,881	(30,401)	11,480		20
21	Clerical & General Office Expenses	32,243	28,581	123,589	184,413		184,413	(30,148)	154,265		21
22	Employee Benefits & Payroll Taxes			399,506	399,506		399,506		399,506		22
23	Inservice Training & Education			9,325	9,325		9,325	778	10,103		23
24	Travel and Seminar							156	156		24
25	Other Admin. Staff Transportation			372	372		372	8,006	8,378		25
26	Insurance-Prop.Liab.Malpractice			80,083	80,083		80,083	1,176	81,259		26
27	Other (specify):*			14,000	14,000		14,000	21,122	35,122		27
28	TOTAL General Administration	94,537	28,581	884,287	1,007,405		1,007,405	(129,390)	878,015		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,027,425	357,419	1,127,364	3,512,208		3,512,208	(96,363)	3,415,845		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	6,148
	REPAIRS & MAINTENANCE	0
		0
		6,148
3	HOUSEKEEPING	
		0
		0
		0
4	LAUNDRY	
	EQUIPMENT REPAIRS & MAINTENANCE	0
		0
		0
5	HEAT & OTHER UTILITIES	
	GAS HEAT	41,770
	ELECTRICITY	35,652
	WATER	19,422
	CABLE TV - LOBBY	5,157
		0
		102,001
6	MAINTENANCE	
	GROUNDS MAINTENANCE	5,441
	PAINTING & DECORATING	300
	BUILDING REPAIRS	0
	MAINTENANCE TRAVEL	0
	EQUIPMENT MAINTENANCE & REPAIR	26,684
	ELEVATOR MAINTENANCE & REPAIR	7,080
	OUTSIDE LABOR	0
	EXTERMINATING SERVICE	3,000
	FIRE SERVICE	5,874
		0
		0
		0
		0
		48,379
7	OTHER	
	SCAVENGER	18,450
	SECURITY SERVICE	70
		0
		0
		18,520
9	MEDICAL DIRECTOR	
	MEDICAL DIRECTOR FEES XVIII B 36-2	31,200
		31,200

LINE	SCHED REF	TOTAL
10	NURSING	
	CONTRACT NURSING XVIII C 53-2	
	LABORATORY & XRAY EXPENSE	200
	PURCHASED SERVICES	945
	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	900
	UTILIZATION REVIEW FEES XVIII B __-2	0
	PHYSICIANS XVIII B __-2	0
	PSYCHIATRIC XVIII B __-2	0
	RN CONSULTANT XVIII B 38-2	8,154
		0
		0
		10,199
10a	THERAPY	
	PHYSICAL THERAPY SERVICES	495
	SPEECH THERAPY SERVICES	726
	OCCUPATIONAL THERAPY SERVICES	17
	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	12,870
		14,108
11	ACTIVITIES	
	CABLE TV - PATIENT ROOMS	
	ACTIVITY REHAB CONSULTANT XVIII B 44-2	4,526
		0
		4,526
12	SOCIAL SERVICES	
	SOCIAL REHABILITATION SERVICES	
	SOCIAL REHABILITATION CONSULTAN XVIII B 45-2	0
	SOCIAL WORKER XVIII B 45-2	7,996
		0
		7,996
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	85,000
	DIRECTORS FEES		
18	DIRECTORS FEES		0
19	PROFESSIONAL SERVICES		
	DATA PROCESSING	XIX C	10,979
	ADMINISTRATIVE CONSULTANTS	XIX C	93,000
	PROFESSIONAL FEES	XIX C	26,552
			0
			130,531
20	FEES,SUBSCRIPTIONS,PROMOTIONS		
	ENTERTAINMENT & MARKETING	VI 19 XIX F	0
	ADV & PROMO-NON PATIENT RELATED	VI 25 XIX F	31,756
	EMPLOYEE WANT ADS	XIX F	8,325
	CONTRIBUTIONS	VI 20 XIX F	0
	DUES & SUBSCRIPTIONS	XIX F	162
	LICENSES & PERMITS	XIX F	1,413
	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	225
	PATIENT BACKGROUND CHECKS	XIX F	0
			41,881
21	CLERICAL & GENERAL OFFICE EXPENSES		
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)		6,610
	EQUIPMENT REPAIR & MAINTENANCE		12,263
	OUTSIDE CLERICAL SERVICES		36,290
	PENALTIES / OVERDRAFT CHARGES	VI 18	23,251
	HOME OFFICE EXPENSE		36,185
	THEFT & DAMAGE LOSS		0
	TELEPHONE		8,990
	MESSENGER SERVICE		0
			0
			123,589

LINE		SCHED REF	TOTAL
22	EMPLOYEE BENEFITS & PAYROLL TAXES		
	FICA TAXES	XIX D	152,359
	UNEMPLOYMENT COMPENSATION	XIX D	25,297
	WORKERS COMPENSATION INSURANC	XIX D	108,447
	HOSPITALIZATION INSURANCE	XIX D	80,336
	EMPLOYEE BENEFITS - OTHER	XIX D	3,044
	EMPLOYEE PHYSICAL EXAMS	XIX D	0
	INSURANCE - EXECUTIVE LIFE	VI 21/XIX D	0
	PENSION/PROFIT SHARING PLANS	XIX D	27,224
	CHICAGO HEAD TAX	XIX D	2,799
			0
			399,506
23	INSERVICE TRAINING & EDUCATION		
	EDUCATION & SEMINARS		9,325
			9,325
24	TRAVEL & SEMINARS		
	EDUCATION & SEMINARS	XIX G	0
	TRAVEL	XIX G	0
			0
25	ADMIN. STAFF TRANSPORTATION		
	TRANSPORTATION - STAFF		372
			372
26	INSURANCE - PROP. LIAB & MALPRACTICE		
	GENERAL INSURANCE		80,083
			80,083
27	OTHER		
	BAD DEBTS	VI 24	14,000
			14,000

GRAND TOTAL COLUMN 3 OTHER

1,127,364

PARK HOUSE NURSING & REHAB CTR
SCHEDULES
12/31/2009

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

TOTAL FOOD PURCHASE	167,998
LESS SALES TAX	<u>(300)</u>
NET FOOD	167,698

TOTAL PATIENT CENSUS	33,669
TIME 3 MEALS PER DAY	<u>3</u>
TOTAL PATIENT MEALS	101,007

ADD # EMPLOYEE MEALS/DAY	0
TIME # DAYS	<u>365</u>
TOTAL EMPLOYEE MEALS	0

PATIENT MEALS	101,007
ADD EMPLOYEE MEALS	<u>0</u>
TOTAL MEALS/YEAR	101,007

NET FOOD	167,698
DIVIDE TOTAL MEALS/YEAR	<u>101,007</u>

COST PER MEAL	1.66
TIME EMPLOYEE MEALS	<u>0</u>
EMPLOYEE MEAL RECLASSIFICATION	0

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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			38,341	38,341		38,341	55,405	93,746			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			213	213		213	402,253	402,466			32
33	Real Estate Taxes			74,637	74,637		74,637	3,820	78,457			33
34	Rent-Facility & Grounds			347,702	347,702		347,702	(347,702)				34
35	Rent-Equipment & Vehicles			18,484	18,484		18,484	5,465	23,949			35
36	Other (specify):* TAG			15,600	15,600		15,600	(15,600)				36
37	TOTAL Ownership			494,977	494,977		494,977	103,641	598,618			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		35,154	95,798	130,952		130,952		130,952			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			58,035	58,035		58,035		58,035			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		35,154	153,833	188,987		188,987		188,987			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,027,425	392,573	1,776,174	4,196,172		4,196,172	7,278	4,203,450			45

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

Facility Name & ID Number **PARK HOUSE NURSING & REHAB CTR**

0050740

Report Period Beginning: **01/01/2009**

Ending: **12/31/2009**

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	5,567	30		9
10	Interest and Other Investment Income	(2,231)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(300)	2		13
14	Non-Care Related Interest	(213)	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(23,251)	21		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(7,697)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(14,000)	27		24
25	Fund Raising, Advertising and Promotional	(31,756)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (73,881)		\$	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)	81,159		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 81,159		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B)	\$ 7,278		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

STATE OF ILLINOIS
 PARK HOUSE NURSING & REHAB CTR

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

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
1		\$	1
2			2
3			3
4			4
5			5
6			6
7			7
8			8
9			9
10			10
11			11
12			12
13			13
14			14
15			15
16			16
17			17
18			18
19			19
20			20
21			21
22			22
23			23
24			24
25			25
26			26
27			27
28			28
29			29
30			30
31			31
32			32

33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total		0	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number PARK HOUSE NURSING & REHAB CTR# 0050740

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	(300)	0	0	0	0	0	0	0	0	0	0	(300)	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	0	10,285	3	0	0	0	0	0	0	0	10,288	6
7	Other (specify):*	0	0	70	0	0	0	0	0	0	0	0	70	7
8	TOTAL General Services	(300)	0	10,355	3	0	10,058	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	18,353	0	0	0	0	0	0	0	0	18,353	10
10a	Therapy	0	0	4,616	0	0	0	0	0	0	0	0	4,616	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	22,969	0	0	0	0	0	0	0	0	22,969	16
	C. General Administration													
17	Administrative	0	0	(5,480)	0	0	0	0	0	0	0	0	(5,480)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(7,697)	0	(46,902)	(40,000)	0	0	0	0	0	0	0	(94,599)	19
20	Fees, Subscriptions & Promotions	(31,756)	0	1,338	17	0	0	0	0	0	0	0	(30,401)	20
21	Clerical & General Office Expenses	(23,251)	0	33,062	(39,959)	0	0	0	0	0	0	0	(30,148)	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	622	156	0	0	0	0	0	0	0	778	23
24	Travel and Seminar	0	0	151	5	0	0	0	0	0	0	0	156	24
25	Other Admin. Staff Transportation	0	0	6,665	1,341	0	0	0	0	0	0	0	8,006	25
26	Insurance-Prop.Liab.Malpractice	0	0	1,176	0	0	0	0	0	0	0	0	1,176	26
27	Other (specify):*	(14,000)	0	33,435	1,687	0	0	0	0	0	0	0	21,122	27
28	TOTAL General Administration	(76,704)	0	24,067	(76,753)	0	(129,390)	28						
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(77,004)	0	57,391	(76,750)	0	(96,363)	29						

STATE OF ILLINOIS

Summary B

Facility Name & ID Number PARK HOUSE NURSING & REHAB CTR# 0050740

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	5,567	44,249	5,589	0	0	0	0	0	0	0	0	55,405	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(2,444)	339,472	65,225	0	0	0	0	0	0	0	0	402,253	32
33	Real Estate Taxes	0	0	3,820	0	0	0	0	0	0	0	0	3,820	33
34	Rent-Facility & Grounds	0	(347,702)	0	0	0	0	0	0	0	0	0	(347,702)	34
35	Rent-Equipment & Vehicles	0	0	5,465	0	0	0	0	0	0	0	0	5,465	35
36	Other (specify):*	0	0	(15,600)	0	0	0	0	0	0	0	0	(15,600)	36
37	TOTAL Ownership	3,123	36,019	64,499	0	103,641	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)	(73,881)	36,019	121,890	(76,750)	0	0	0	0	0	0	0	7,278	45

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
SCHEDULE ATTACHED		SCHEDULE ATTACHED		CAREPLUS MGMT	SKOKIE	MGMT/CLERICAL
				TIMBER POINT ASSOCIATES LLC		REAL ESTATE
					SKOKIE	
				CAREPLUS REHABILITATIVE SERVICES		THERAPY
					SKOKIE	
				EXTENDED CARE CONSULTING/CLINICAL		MGMT/CLERICAL
					EVANSTON	

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	\$ 347,702	2320 S LAWDALE		\$	\$ (347,702)	1
2	V	30 SL DEPRECIATION				38,397	38,397	2
3	V	32 INTEREST				339,472	339,472	3
4	V							4
5	V							5
6	V							6
7	V							7
8	V							8
9	V	30 DEPRECIATION		CAREPLUS REHAB		5,852	5,852	9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 347,702			\$ 383,721	\$ * 36,019	14

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

Facility Name & ID Number PARK HOUSE NURSING & REHAB CTR# 0050740Report 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	6 MAINT & REPAIRS	\$	CAREPLUS MANAGEMENT		\$ 5,481	\$	5,481	15
16	V	6 MAINTENANCE SALARIES				4,804		4,804	16
17	V	7 SECURITY				70		70	17
18	V	10 NURSING SALARIES				18,353		18,353	18
19	V	10a THERAPY SALARIES				4,616		4,616	19
20	V	17 ADMIN SALARIES	85,000			79,520		(5,480)	20
21	V	19 PROFESSIONAL FEES	53,000			6,098		(46,902)	21
22	V	20 ADVERTISING				1,338		1,338	22
23	V	21 OFFICE EXPENSE	31,800			13,066		(18,734)	23
24	V	21 OFFICE SALARIES				51,796		51,796	24
25	V	23 SEMINARS				622		622	25
26	V	24 TRAVEL				151		151	26
27	V	25 TRANSPORTATION				6,665		6,665	27
28	V	26 INSURANCE				1,176		1,176	28
29	V	27 EMPLOYEE BENEFITS				33,435		33,435	29
30	V	30 DEPRECIATION				5,589		5,589	30
31	V	32 INTEREST				61,184		61,184	31
32	V	32 INTEREST TAG 18				4,041		4,041	32
33	V	33 REAL ESTATE TAX TAG 18				3,820		3,820	33
34	V	35 EQUIPMENT RENT				5,465		5,465	34
35	V	36 OFFICE RENT	15,600					(15,600)	35
36	V								36
37	V								37
38	V								38
39	Total		\$ 185,400			\$ 307,290	\$ *	121,890	39

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	6 MAINT & REPAIRS	\$	EXTENDED CARE CONSULTING/CLINICAL		\$ 3	\$ 3
16	V	19 PROFESSIONAL FEES	40,000				(40,000)
17	V	20 ADVERTISING				17	17
18	V	21 OFFICE EXPENSES	40,675			716	(39,959)
19	V	23 SEMINARS				156	156
20	V	24 TRAVEL				5	5
21	V	25 TRANSPORTATION				1,341	1,341
22	V	26 INSURANCE					
23	V	27 EMPLOYEE BENEFITS				1,687	1,687
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		\$ 80,675			\$ 3,925	\$ * (76,750)

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

Facility Name & ID Number PARK HOUSE NURSING & REHAB CTR # 0050740 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 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	JACOB BAKST	DIR OPERATIONS							\$ 18,442	17-7	1
2	SHERWIN RAY	ADMIN CONSLT			SCHEDULE ATTACHED				18,442	17-7	2
3	ROSLYN INDICH	CONTROLLER A/P							5,630	17-7	3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 42,514		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 NURSING & REHAB CTR

0050740

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
 Street Address 2201 MAIN ST
 City / State / Zip Code EVANSTON,IL 60202
 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	MAINT & REPAIRS	PATIENT DAYS	8	\$ 57,951	\$	33,669	\$ 5,481	1
2	6	MAINTENANCE SALARIES	PATIENT DAYS	8	50,792	50,792	33,669	4,804	2
3	7	SECURITY	PATIENT DAYS	8	738		33,669	70	3
4	10	NURSING SALARIES	PATIENT DAYS	8	194,059	194,059	33,669	18,353	4
5	10a	THERAPY SALARIES	PATIENT DAYS	8	48,814	48,814	33,669	4,616	5
6	17	ADMIN SALARIES	PATIENT DAYS	8	840,831	840,831	33,669	79,520	6
7	19	PROFESSIONAL FEES	PATIENT DAYS	8	64,478		33,669	6,098	7
8	20	ADVERTISING	PATIENT DAYS	8	14,148		33,669	1,338	8
9	21	OFFICE EXPENSE	PATIENT DAYS	8	138,156		33,669	13,066	9
10	21	OFFICE SALARIES	PATIENT DAYS	8	547,685	547,685	33,669	51,796	10
11	23	SEMINARS	PATIENT DAYS	8	6,573		33,669	622	11
12	24	TRAVEL	PATIENT DAYS	8	1,601		33,669	151	12
13	25	TRANSPORATION	PATIENT DAYS	8	70,475		33,669	6,665	13
14	26	INSURANCE	PATIENT DAYS	8	12,432		33,669	1,176	14
15	27	EMPLOYEE BENEFITS	PATIENT DAYS	8	353,538		33,669	33,435	15
16	30	DEPRECIATION	PATIENT DAYS	8	59,093		33,669	5,589	16
17	32	INTEREST	PATIENT DAYS	8	646,953		33,669	61,184	17
18	32	INTEREST TAG 18	PATIENT DAYS	8	42,734		33,669	4,041	18
19	33	REAL ESTATE TAX TAG 18	PATIENT DAYS	8	40,394		33,669	3,820	19
20	35	EQUIPMENT RENT	PATIENT DAYS	8	57,785		33,669	5,465	20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 3,249,230	\$ 1,682,181		\$ 307,290	25

Facility Name & ID Number PARK HOUSE NURSING & REHAB CTR

0050740

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

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

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

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	MAINT & REPAIRS	PATIENT DAYS	58,508	8	\$ 32	5,507	\$ 3	1
2	19	PROFESSIONAL FEES	PATIENT DAYS	58,508	8		5,507		2
3	20	ADVERTISING	PATIENT DAYS	58,508	8	184	5,507	17	3
4	21	OFFICE EXPENSES	PATIENT DAYS	58,508	8	7,605	5,507	716	4
5	23	SEMINARS	PATIENT DAYS	58,508	8	1,657	5,507	156	5
6	24	TRAVEL	PATIENT DAYS	58,508	8	57	5,507	5	6
7	25	TRANSPORTATION	PATIENT DAYS	58,508	8	14,249	5,507	1,341	7
8	26	INSURANCE	PATIENT DAYS	58,508	8		5,507		8
9	27	EMPLOYEE BENEFITS	PATIENT DAYS	58,508	8	17,921	5,507	1,687	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	\$	\$ 3,925	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**					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	PACIFIC LIFE		X	MORTGAGE			\$	\$ 2,364,164			\$ 339,472	1					
2												2					
3												3					
4												4					
5												5					
	Working Capital																
6												6					
7												7					
8												8					
9	TOTAL Facility Related						\$	\$ 2,364,164			\$ 339,472	9					
	B. Non-Facility Related*																
10	NON CARE RELATED										213	10					
11												11					
12												12					
13												13					
14	TOTAL Non-Facility Related						\$	\$			\$ 213	14					
15	TOTALS (line 9+line14)						\$	\$ 2,364,164			\$ 339,685	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.		\$	73,000	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.)		\$	72,211	2
3. Under or (over) accrual (line 2 minus line 1).		\$	(789)	3
4. Real Estate Tax accrual used for 2009 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	75,426	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.		\$	74,637	7
Real Estate Tax History:				
Real Estate Tax Bill for Calendar Year:	2004	79,779	8	
	2005	80,592	9	
	2006	72,265	10	
	2007	71,493	11	
	2008	72,211	12	
THE RE TAX ACCRUAL IS BASED ON ~102% OF THE 2008 RE TAX BILL FOR 2 MONTHS \$12,637, THE BALANCE IS THE ACCRUAL FROM PARK HOUSE LTD.				
				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

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 PARK HOUSE NURSING & REHAB CTR COUNTY COOK

FACILITY IDPH LICENSE NUMBER 0050740

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>16-26-105-075-0000</u>	<u>NURSING HOME</u>	\$ <u>31,476.36</u>	\$ <u>31,476.36</u>
2.	<u>16-26-105-079-0000</u>	<u>NURSING HOME</u>	\$ <u>20,329.64</u>	\$ <u>20,329.64</u>
3.	<u>16-26-105-080-0000</u>	<u>NURSING HOME</u>	\$ <u>20,404.67</u>	\$ <u>20,404.67</u>

4.	_____	_____	\$ _____	\$ _____
5.	_____	_____	\$ _____	\$ _____
6.	_____	_____	\$ _____	\$ _____
7.	_____	_____	\$ _____	\$ _____
8.	_____	_____	\$ _____	\$ _____
9.	_____	_____	\$ _____	\$ _____
10.	_____	_____	\$ _____	\$ _____
		TOTALS	\$ <u>72,210.67</u>	\$ <u>72,210.67</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: 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	<u>NURSING HOME</u>			\$ <u>40,650</u>	1
2					2
3	TOTALS			\$ 40,650	3

Facility Name & ID Number **PARK HOUSE NURSING & REHAB CTR**# **0050740**

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	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	\$	\$ 804,728	4
5											5
6											6
7											7
8		RELATED PARTY				2,298		2,298			8
		Improvement Type**									
9		LEASEHOLD IMPROVEMENTS	1989		17,739	563	20	645	82	17,739	9
10		LEASEHOLD IMPROVEMENTS	1989		4,204		15			4,204	10
11		LEASEHOLD IMPROVEMENTS	1990		11,700	371	20	585	214	11,304	11
12		LEASEHOLD IMPROVEMENTS	1991		17,413	553	20	871	318	16,113	12
13		LEASEHOLD IMPROVEMENTS	1992		55,138	1,858	31.5	1,750	(108)	30,946	13
14		LEASEHOLD IMPROVEMENTS	1993		26,399	748	31.5	1,858	1,110	15,867	14
15		LEASEHOLD IMPROVEMENTS	1994		3,400	87	39	87		1,374	15
16		ROOF REPAIR	1995		1,500	38	39	38		553	16
17		ROOF-TOP HEAT/A/C	1996		10,000	256	39	256		3,553	17
18		CEILING TILE/DUMBWAITER REPAIR	1996		12,253	314	39	314		4,279	18
19											19
20		RE-ROOF	1996		80,861	2,073	39	2,073		27,638	20
21		FIXTURES/WINDOWS	1996		3,850	99	39	99		1,306	21
22		WINDOWS	1997		18,900	484	39	484		5,974	22
23		ROOF REPAIR & ROOF-TOP HEAT/A/C INSTALLATION	1997		3,228	83	39	83		1,035	23
24		DOOR & FLOORING	1997		2,922	75	39	75		941	24
25		ELEVATOR REPAIR	1997		3,125	80	39	80		990	25
26		WINDOWS	1998		12,600	323	39	323		3,796	26
27		TILE & FLOORING	1998		23,810	611	39	611		7,163	27
28		ELECTRICAL, PLUMBING AND ELEVATOR REPAIR	1998		31,238	801	39	801		9,320	28
29		NEW NURSE STATION	1998		24,271	622	39	622		7,387	29
30		WINDOW TREATMENTS AND BRAILLE SIGNS	1998		3,478	89	39	89		1,042	30
31		FIRE SYSTEM UPGRADE AND DAMPERS	1998		8,833	227	39	227		2,570	31
32		REAR PARKING LOT REPAIRS	1998		10,550	703	15	703		8,088	32
33		WINDOWS/CLOSETS/OUTLETS/DUMBWAITS/ROOF	1999		23,174	594	39	594		6,361	33
34		ROOF REPAIR	1999		18,365	471	39	471		4,965	34
35		FRONT RAMP REPAIR	2000		1,200	44	27.5	44		382	35
36		VINYL TILE/KITCHEN	2000		6,213	226	27.5	226		2,138	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 **PARK HOUSE NURSING & REHAB CTR**# **0050740**

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	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	\$	\$ 1,046	37
38	SIDEWALK/TUCKPOINTING	2001	5,500	367	15	367		3,119	38
39	KEYPAD ENTRY SYSTEM	2001	3,800	138	27.5	138		1,121	39
40	BOILER	2002	5,229	190	27.5	190		1,417	40
41	AC UNITS	2002	6,365	231	27.5	231		1,723	41
42	FLOORING	2002	2,328	85	27.5	85		634	42
43	FIRE PUMP REPAIR	2003	1,750	64	27.5	64		412	43
44	ELECTRICAL TO ROOFTOP UNIT	2003	1,951	71	27.5	71		459	44
45	PAINTING	2003	20,800	756	27.5	756		4,884	45
46	CEILING & DOOR REPAIR	2003	1,180	43	27.5	43		278	46
47	CONCRETE REPAIRS	2003	2,961	108	27.5	108		698	47
48	REBUILD NEW BATHROOMS	2004	7,478	272	27.5	272		1,485	48
49	WATER PUMP	2004	2,547	93	27.5	93		507	49
50	BOILER,BURNER,BACKSPLASH,GREASE TRAP/EXCAVATI	2005	8,945	325	27.5	325		1,453	50
51	WALL AC/CARPET	2005	14,131	514	27.5	514		2,293	51
52	ELEVATOR REPAIR/ ROOFTOP AC	2005	22,770	828	5	828		3,686	52
53	PAINTING	2006	13,760	1,585	15	1,585		11,382	53
54	LANDSCAPING & CEMENT WORK	2006	13,400	893	27.5	893		3,126	54
55	BATHROOM REMODEL	2006	3,800	138	27.5	138		477	55
56	EMERGENCY LIGHTS, ALARMS & LOCKS	2006	9,288	338		338		1,169	56
57									57
58									58
59	CARE PLUS REHAB:								59
60	WINDOWS	2004	11,385	292	39	292		1,545	60
61	FLOORING	2004	30,110	772	39	772		4,600	61
62	HEAT EXCHANGER FOOFTOP UNIT	2007	2,772	101	39	101		248	62
63	PAINTING BUILDING	2007	2,560	93	39	93		229	63
64	ELECTRICAL WORK	2007	9,020	328	39	328		806	64
65	SMOKE & EXHAUST FANS	2007	5,249	191	39	191		469	65
66	COMPRESSOR & CONDENSING UNIT	2007	3,949	144	39	144		354	66
67	WALL AC UNITS CEILING TILES	2007	2,319	84	39	84		207	67
68	CEMENT WORK	2007	2,100	76	39	76		187	68
69	FENCE & GATES	2007	5,341	194		194		477	69
70	TOTAL (lines 4 thru 69)		\$ 1,871,766	\$ 62,521		\$ 64,137	\$ 1,616	\$ 1,052,247	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	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 1,871,766	\$ 62,521		\$ 64,137	\$ 1,616	\$ 1,052,247	1
2	HEAT PUMP/SUMP PUMP	2008	14,059	511	27.5	511		767	2
3	REPLACE PIPE AND SEWER LINE	2008	8,100	295	27.5	295		442	3
4	WIRE DOOR TO ALARM	2008	3,231	117	27.5	117		176	4
5	BATHROOM SHOWERS, TUBS, SINKS, TOILETS, TILE	2009	128,320	2,139	27.5	2,139		2,139	5
6	SPRINKLER HEADS	2009	4,375	73	27.5	73		73	6
7	ROOF REPAIR	2009	2,300	38	27.5	38		38	7
8	ELECTRICAL WORK	2009	4,500	75	27.5	75		75	8
9	CARPET & FLOORING	2009	8,300	139	27.5	139		139	9
10	WATER HEATER & ROOF EXHAUST	2009	6,909	115	27.5	115		115	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)		\$ 2,051,860	\$ 66,023		\$ 67,639	\$ 1,616	\$ 1,056,211	34

**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	\$ 240,230	\$ 16,924	\$ 22,654	\$ 5,730	10 YRS	\$ 134,455	71
72	Current Year Purchases	3,235	1,941	162	(1,779)	10 YRS	162	72
73	Fully Depreciated Assets	157,811					157,811	73
74	RELATED PARTY		3,291	3,291				74
75	TOTALS	\$ 401,276	\$ 22,156	\$ 26,107	\$ 3,951		\$ 292,428	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)	\$ 2,493,786	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 88,179	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 93,746	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 5,567	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,348,639	85

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

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

G. Construction-in-Progress

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

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: NA

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

If NO, see instructions. YES NO

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

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

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

Fiscal Year Ending Annual Rent

12. _____ /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: \$ 17,306 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>1,178</u>	17
18					18
19					19
20					20
21	TOTAL		\$	\$ <u>1,178</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 PARK HOUSE NURSING & REHAB CTR # 0050740 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		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	1 Schedule V Line & Column Reference	2		3		4		5		6		7		8	
			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	\$			\$	30,360	\$					\$	30,360	1
2	Licensed Speech and Language Development Therapist	39-3	hrs					1,155							1,155	2
3	Licensed Recreational Therapist		hrs													3
4	Licensed Physical Therapist	39-3	hrs					7,970							7,970	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							35,154					35,154	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs													10
11	Academic Education		hrs													11
12	Other (specify): <u>THERAPY</u>							56,313							56,313	12
13	Other (specify):															13
14	TOTAL			\$			\$	95,798	\$	35,154			\$	130,952	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 NURSING & REHAB CTR**# **0050740**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 <u>14,000</u>)	660,235		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	19,202		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>RE TAX ESCROW</u>	16,200		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 695,637	\$	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			15
16	Equipment, at Historical Cost			16
17	Accumulated Depreciation (book methods)			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 RSV</u>			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 695,637	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 236,897	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	22,351		30
31	Accrued Taxes Payable (excluding real estate taxes)	15,551		31
32	Accrued Real Estate Taxes(Sch.IX-B)	12,637		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>RELATED PARTY</u>	476,216		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 763,652	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 763,652	\$	46
47	TOTAL EQUITY (page 18, line 24)	\$ (68,015)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 695,637	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	222,348	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)	\$ 222,348	17
	B. Transfers (Itemize):		
18			18
19	ADJUST FOR PARK HOUSE LTD.	(290,363)	19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$ (290,363)	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ (68,015)	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	\$ 4,430,570	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,430,570	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	2,231	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 2,231	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)	\$ 4,432,801	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	819,482	31
32	Health Care	1,685,321	32
33	General Administration	1,007,405	33
B. Capital Expense			
34	Ownership	494,977	34
C. Ancillary Expense			
35	Special Cost Centers	130,952	35
36	Provider Participation Fee	58,035	36
D. Other Expenses (specify):			
37	OUT-OF-PERIOD EXPENSES	14,281	37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 4,210,453	40
41	Income before Income Taxes (line 30 minus line 40)**	222,348	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 222,348	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 NURSING & REHAB CTR**

0050740

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	2,464	2,543	\$ 69,825	\$ 27.46	1
2	Assistant Director of Nursing	2,040	2,160	57,872	26.79	2
3	Registered Nurses	3,560	3,872	76,351	19.72	3
4	Licensed Practical Nurses	13,053	14,170	336,555	23.75	4
5	CNAs & Orderlies	43,791	48,480	470,915	9.71	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	4,569	4,887	82,044	16.79	8
9	Activity Director	2,020	2,189	20,154	9.21	9
10	Activity Assistants	8,402	9,332	113,067	12.12	10
11	Social Service Workers	4,176	4,846	64,715	13.35	11
12	Dietician					12
13	Food Service Supervisor	2,074	2,265	38,020	16.79	13
14	Head Cook	3,435	3,884	35,779	9.21	14
15	Cook Helpers/Assistants	11,040	12,437	108,827	8.75	15
16	Dishwashers					16
17	Maintenance Workers	2,514	2,712	40,113	14.79	17
18	Housekeepers	14,028	15,369	132,193	8.60	18
19	Laundry	4,018	4,470	39,878	8.92	19
20	Administrator	2,056	2,163	62,294	28.80	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	2,086	2,180	32,243	14.79	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	1,995	2,134	24,133	11.31	31
32	Other Health Care(specify)	11,474	12,279	222,447	18.12	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	138,795	152,372	\$ 2,027,425 *	\$ 13.31	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	\$ 6,148	1-3	35
36	Medical Director	O	31,200	9-3	36
37	Medical Records Consultant	N	0	10-3	37
38	Nurse Consultant	T	8,154	10-3	38
39	Pharmacist Consultant	H	900	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	4,526	11-3	44
45	Social Service Consultant	E	7,996	12-3	45
46	Other(specify)	S			46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 58,924		49

C. CONTRACT NURSES

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

Facility Name & ID Number **PARK HOUSE NURSING & REHAB CTR**

0050740

Report Period Beginning: **01/01/2009**

Ending: **12/31/2009**

XIX. SUPPORT SCHEDULES

A. Administrative Salaries			Ownership %	Amount	D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function				Description	Amount	Description	Amount	
YECHIEL MASHIACH	ADMINISTRATOR		\$ 62,294	Workers' Compensation Insurance	\$ 108,447	IDPH License Fee	\$		
				Unemployment Compensation Insurance	25,297	Advertising: Employee Recruitment		8,325	
				FICA Taxes	152,359	Health Care Worker Background Check		225	
				Employee Health Insurance	80,336	(Indicate # of checks performed _____)			
				Employee Meals	0	Patient Background Checks		0	
				Illinois Municipal Retirement Fund (IMRF)*		TRUST/FRANCHISE/CONTRIB/ETC		0	
				EMPLOYEE BENEFITS - OTHER	3,044	MARKETING/ADV/PROMO		31,756	
						LICENSES/DUES/SUBSCRIPTIONS		1,575	
TOTAL (agree to Schedule V, line 17, col. 1)			\$ 62,294	PENSION/PROFIT SHARING PLANS	27,224	MGMT CO ALLOC		1,355	
(List each licensed administrator separately.)				CHICAGO HEAD TAX	2,799	TRUST/FRANCHISE/CONTRIB/ETC		0	
						Less: Public Relations Expense	(0)	
B. Administrative - Other						Non-allowable advertising		(31,756)	
						Yellow page advertising	(0)	
Description			Amount						
MANAGEMENT FEE			\$ 85,000						
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 85,000	TOTAL (agree to Schedule V, line 22, col.8)	\$ 399,506	TOTAL (agree to Sch. V, line 20, col. 8)	\$	11,480	
(Attach a copy of any management service agreement)									
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	156	
							Seminar Expense		
								0	
							Entertainment Expense	(
SEE SCHEDULE ATTACHED			130,531				(agree to Sch. V, line 24, col. 8)		
TOTAL (agree to Schedule V, line 19, column 3)			\$ 130,531	TOTAL		\$	TOTAL	\$ 156	
(If total legal fees exceed \$5,000, attach copy of invoices.)									

* Attach copy of IMRF notifications

**See instructions.

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	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

Facility Name & ID Number PARK HOUSE NURSING & REHAB CTR# 0050740Report Period Beginning: 01/01/2009 Ending: 12/31/2009**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. \$ _____ 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 X NO _____ If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
PARK HOUSE LTD. #0034991 11/01/2009
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 58,035
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? NO If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? YES
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? NO For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? N/A Indicate the amount. \$ _____
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? NO
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? 5%
d. Have vehicle usage logs been maintained? NO
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? NO
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? YES
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? NO
Firm Name: _____
- (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.