		FOR OHF USE					

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2004
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2004)

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.

I. IDPH Facility ID Number: 0035394

Facility Name: Blue Island Nursing Home

Address: 2427 W. 127Th (Number) Blue Island (City) 60406 (Zip Code)

County: Cook

Telephone Number: (708) 389-7799 **Fax #** (708) 389-8799

IDPA ID Number: 363647546001

Date of Initial License for Current Owners: 06/01/89

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: David S. Gilfand **Telephone Number:** (847)317-0160

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/04 to 12/31/04 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.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) _____
(Title) _____

Paid Preparer
(Signed) _____ (Date)
(Print Name and Title) David S. Gilfand, E.A.
(Firm Name & Address) David S. Gilfand, Ltd. 520 Lake Cook Rd., Ste 310, Deerfield, IL 60015
(Telephone) (847) 317-0160 Fax # (847) 317-0165

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number Blue Island Nursing Home # 0035394 Report Period Beginning: 01/01/04 Ending: 12/31/04

III. STATISTICAL DATA

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

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3	30	Intermediate (ICF)	30	10,980	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	30	TOTALS	30	10,980	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF					8
9	SNF/PED					9
10	ICF	7,425	616		8,041	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	7,425	616		8,041	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 73.23%

D. How many bed-hold days during this year were paid by Public Aid?
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)
N/A

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 [X]

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

I. On what date did you start providing long term care at this location?
Date started 11/01/63

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 03/24/98 NO [ ]

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

Medicare Intermediary _____

IV. ACCOUNTING BASIS

ACCRUAL	MODIFIED CASH*	CASH*
[X]	[ ]	[ ]

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

Tax Year: 12/31/04 Fiscal Year: 12/31/04

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

Facility Name & ID Number Blue Island Nursing Home # 0035394 Report Period Beginning: 01/01/04 Ending: 12/31/04

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	20,245		1,000	21,245		21,245		21,245			1
2	Food Purchase		56,355		56,355		56,355	(32)	56,323			2
3	Housekeeping	26,299	3,750		30,049		30,049		30,049			3
4	Laundry		2,812		2,812		2,812		2,812			4
5	Heat and Other Utilities			11,580	11,580		11,580		11,580			5
6	Maintenance			8,647	8,647		8,647		8,647			6
7	Other (specify):*											7
8	**TOTAL General Services**	46,544	62,917	21,227	130,688		130,688	(32)	130,656			8
	B. Health Care and Programs											
9	Medical Director											9
10	Nursing and Medical Records	255,897	14,006	540	270,443		270,443		270,443			10
10a	Therapy											10a
11	Activities	27,660	69	1,194	28,923		28,923		28,923			11
12	Social Services			3,163	3,163		3,163		3,163			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	283,557	14,075	4,897	302,529		302,529		302,529			16
	C. General Administration											
17	Administrative	72,296			72,296		72,296		72,296			17
18	Directors Fees											18
19	Professional Services			17,534	17,534		17,534		17,534			19
20	Dues, Fees, Subscriptions & Promotions			1,531	1,531		1,531	(683)	848			20
21	Clerical & General Office Expenses			30,583	30,583		30,583	(23,993)	6,590			21
22	Employee Benefits & Payroll Taxes			44,966	44,966		44,966		44,966			22
23	Inservice Training & Education											23
24	Travel and Seminar			500	500		500		500			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			3,551	3,551		3,551		3,551			26
27	Other (specify):*											27
28	**TOTAL General Administration**	72,296		98,665	170,961		170,961	(24,676)	146,285			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	402,397	76,992	124,789	604,178		604,178	(24,708)	579,470			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.

Facility Name & ID Number Blue Island Nursing Home #0035394 Report Period Beginning: 01/01/04 Ending: 12/31/04

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			200	200		200	10,240	10,440			30
31	Amortization of Pre-Op. & Org.			2,500	2,500		2,500		2,500			31
32	Interest			7,325	7,325		7,325	23,203	30,528			32
33	Real Estate Taxes			50,805	50,805		50,805		50,805			33
34	Rent-Facility & Grounds			42,000	42,000		42,000	(42,000)				34
35	Rent-Equipment & Vehicles			1,068	1,068		1,068		1,068			35
36	Other (specify):*							8,515	8,515			36
37	**TOTAL Ownership**			103,898	103,898		103,898	(42)	103,856			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			16,470	16,470		16,470		16,470			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**			16,470	16,470		16,470		16,470			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	402,397	76,992	245,157	724,546		724,546	(24,750)	699,796			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 Blue Island Nursing Home # 0035394 Report Period Beginning: 01/01/04 Ending: 12/31/04

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.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF 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	(1,084)	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(32)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(683)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(23,993)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (25,792)		$	30

OHF 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 Amount	2 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)	1,042		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 1,042		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (24,750)		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 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

Blue Island Nursing Home

ID# 0035394

Report Period Beginning: 01/01/04

Ending: 12/31/04

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Bank Charges	$ (16,271)	21	1
2	Penalties	(7,722)	21	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**	(23,993)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Blue Island Nursing Home # 0035394 Report Period Beginning: 01/01/04 Ending: 12/31/04

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(32)	0	0	0	0	0	0	0	0	0	0	(32)	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	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(32)	0	0	0	0	0	0	0	0	0	0	(32)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	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	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(683)	0	0	0	0	0	0	0	0	0	0	(683)	20
21	Clerical & General Office Expenses	(23,993)	0	0	0	0	0	0	0	0	0	0	(23,993)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(24,676)	0	0	0	0	0	0	0	0	0	0	(24,676)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(24,708)	0	0	0	0	0	0	0	0	0	0	(24,708)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Blue Island Nursing Home # 0035394 **Report Period Beginning:** 01/01/04 **Ending:** 12/31/04

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(1,084)	11,324	0	0	0	0	0	0	0	0	0	10,240	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	23,203	0	0	0	0	0	0	0	0	0	23,203	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	(42,000)	0	0	0	0	0	0	0	0	0	(42,000)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	8,515	0	0	0	0	0	0	0	0	0	8,515	36
37	**TOTAL Ownership**	(1,084)	1,042	0	0	0	0	0	0	0	0	0	(42)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(25,792)	1,042	0	0	0	0	0	0	0	0	0	(24,750)	45

Facility Name & ID Number Blue Island Nursing Home # 0035394 Report Period Beginning: 01/01/04 Ending: 12/31/04

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
Zohar Hochenbaum	50.00%	Rainbow Beach Nursing Center, Inc	Chicago	MZL Limited	Chicago	Bldg., Partnership
Michael Perl	50.00%					

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. [X] 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	34	Rental Income	$ 42,000	MZL Limited Partnership	100.00%	$	$ (42,000)	1
2	V	30	Depreciation		MZL Limited Partnership	100.00%	11,324	11,324	2
3	V	36	Finance Charges		MZL Limited Partnership	100.00%	8,515	8,515	3
4	V	32	Interest		MZL Limited Partnership	100.00%	23,203	23,203	4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 42,000			$ 43,042	$ * 1,042	14

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

Facility Name & ID Number Blue Island Nursing Home # 0035394 Report Period Beginning: 01/01/04 Ending: 12/31/04

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	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week: Hours	Percent	Compensation Included in Costs for this Reporting Period**: Description	Amount	Schedule V. Line & Column Reference	
1	Zohar Hochenbaum	Owner	Asst. Admin.	50%	See Attached	10	20%	Salary	$ 10,750	17-01	1
2	Rita Hochenbaum	Relative	Administrative		See Attached	10	25%	Salary	8,400	17-01	2
3	Esther Perl	Relative	Administrative		See Attached	20	50%	Salary	8,400	17-01	3
4	Jonathan Perl	Relative	Administrative		See Attached	2	5%	Salary	2,000	17-01	4
5	Rami Hochenbaum	Relative	Administrative		See Attached	2	5%	Salary	2,000	17-01	5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 31,550		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

ZOHAR HOCHENBAUM
AVERAGE HOURS WORKED
AND COMPENSATION
01/01/04 - 12/31/04

FACILITY NAME	AVERAGE HOURS	SALARY FROM THE FACILITY	MANAGEMENT FEES FROM THE FACILITY	TOTAL COMPENSATION
RAINBOW BEACH	40	$ -	$ 60,319.00	$ 60,319.00
BLUE ISLAND	10	10,750.00	-	$ 10,750.00
OTHER		-	-	$ -
	50	$ 10,750.00	$ 60,319.00	$ 71,069.00

RITA HOCHENBAUM
AVERAGE HOURS WORKED
AND COMPENSATION
01/01/04 - 12/31/04

FACILITY NAME	AVERAGE HOURS	SALARY FROM THE FACILITY	MANAGEMENT FEES FROM THE FACILITY	TOTAL COMPENSATION
RAINBOW BEACH	30	$ 52,952.00	$ -	$ 52,952.00
BLUE ISLAND	10	8,400.00	-	$ 8,400.00
OTHER		-	-	$ -
	40	$ 61,352.00	$ -	$ 61,352.00

ESTHER PERL
AVERAGE HOURS WORKED
AND COMPENSATION
01/01/04 - 12/31/04

FACILITY NAME	AVERAGE HOURS	SALARY FROM THE FACILITY	MANAGEMENT FEES FROM THE FACILITY	TOTAL COMPENSATION
RAINBOW BEACH	20	$ 3,500.00	$ -	$ 3,500.00
BLUE ISLAND	10	8,400.00	-	$ 8,400.00
OTHER		-	-	$ -
	30	$ 11,900.00	$ -	$ 11,900.00

JONATHAN PERL
AVERAGE HOURS WORKED
AND COMPENSATION
01/01/04 - 12/31/04

FACILITY NAME	AVERAGE HOURS	SALARY FROM THE FACILITY	MANAGEMENT FEES FROM THE FACILITY	TOTAL COMPENSATION
RAINBOW BEACH			$ -	$ -
BLUE ISLAND	2	$ 2,000.00	-	$ 2,000.00
OTHER		-	-	$ -
	2	$ 2,000.00	$ -	$ 2,000.00

RAMI HOCHENBAUM
AVERAGE HOURS WORKED
AND COMPENSATION
01/01/04 - 12/31/04

FACILITY NAME	AVERAGE HOURS	SALARY FROM THE FACILITY	MANAGEMENT FEES FROM THE FACILITY	TOTAL COMPENSATION
RAINBOW BEACH	2	$ 2,000.00	$ -	$ 2,000.00
BLUE ISLAND	2	2,000.00	-	$ 2,000.00
OTHER		-	-	$ -
	4	$ 4,000.00	$ -	$ 4,000.00

Facility Name & ID Number Blue Island Nursing Home # 0035394 Report Period Beginning: 01/01/04 Ending: 12/31/04

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 [X]

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

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

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

Facility Name & ID Number Blue Island Nursing Home # 0035394 Report Period Beginning: 01/01/04 Ending: 12/31/04

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	Great Lakes Bank		X	Mortgage	$2,484.00	03/28/98	$ 297,000	$ 262,044		Prime+1	$ 23,203	1
2												2
3												3
4												4
5												5
	Working Capital											
6	Great Lakes Bank		X	Line of Credit				71,879	Demand	1.5%	7,325	6
7												7
8												8
9	TOTAL Facility Related				$2,484.00		$ 297,000	$ 333,923			$ 30,528	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 297,000	$ 333,923			$ 30,528	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.)

Facility Name & ID Number Blue Island Nursing Home # 0035394 Report Period Beginning: 01/01/04 Ending: 12/31/04

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

B. Real Estate Taxes

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

1. Real Estate Tax accrual used on 2003 report.	$	27,000	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.)	$	48,805	2
3. Under or (over) accrual (line 2 minus line 1).	$	21,805	3
4. Real Estate Tax accrual used for 2004 report. (Detail and explain your calculation of this accrual on the lines below.)	$	29,000	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	50,805	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1999	22,634	8
	2000	24,254	9
	2001	24,674	10
	2002	26,314	11
	2003	27,671	12

2004 Real Estate Tax Accrual = $ 27,671*1.05= $ 29,000

RE Taxes Paid in 2004: 2003 $27,671, 1999 $ 3,773, 2000-2001 $ 17,361

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2003	$	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:** 2003 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 2003 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2003.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2003 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2004 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2003 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Blue Island Nursing Home COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0035394

CONTACT PERSON REGARDING THIS REPORT David S. Gilfand

TELEPHONE (847) 317-0160 FAX #: (847) 317-0165

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2003 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 2003.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	24-36-205-013-0000	Long-Term Care Property	$ 17,577.50	$ 17,577.50
2.	24-36-205-024-0000	Long-Term Care Property	$ 1,332.18	$ 1,332.18
3.	24-36-205-025-0000	Long-Term Care Property	$ 1,332.18	$ 1,332.18
4.	24-36-205-034-0000	Long-Term Care Property	$ 7,429.30	$ 7,429.30
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 27,671.16	$ 27,671.16

B. **Real Estate Tax Cost Allocations**

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

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

C. **Tax Bills**

Attach a copy of the original 2003 tax bills which were listed in Section A to this statement. Be sure to use the 2003 tax bill which is normally paid during 2004.

Facility Name & ID Number Blue Island Nursing Home # 0035394 Report Period Beginning: 01/01/04 Ending: 12/31/04

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 5,651 B. General Construction Type: Exterior Brick Vaneer Frame _____ Number of Stories One

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (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? [X] (a) Own the Equipment [X] (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, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

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

1. Total Amount Incurred: 75,000 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: 2,500 4. Dates Incurred: 03/98

Nature of Costs: Do not Compete ($50,000) = $2,500
(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	Building	6,617	1963	$ 6,458	1
2	Parking Lots	6,250	1972	12,388	2
3	TOTALS	12,867		$ 18,846	3

Facility Name & ID Number Blue Island Nursing Home # 0035394 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4			1963	1953	$ 99,978	$ 7,308	35	$	$ (7,308)	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			1974	6,473		20	196	196	980	9
10	Various			1975	24,442		20	741	741	3,704	10
11	Various			1976	4,502		20	136	136	681	11
12	Various			1983	4,673		20				12
13	Various			1988	1,493		20				13
14	Various			1989	4,888		20				14
15	Various			1990	10,209		20				15
16	Various			1991	7,885		20	148	148	739	16
17	Various			1992	2,973		20				17
18	Various			1994	1,973		20			494	18
19	Various			1995	625		20			234	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

*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 Blue Island Nursing Home # 0035394 Report Period Beginning: 01/01/04 Ending: 12/31/04

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	
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	Related Building Company (Pages 12-BLDG & 12A-BLDG)								67
68	Related Party Allocations (Pages 12-REP & 12A-REP)								68
69	Financial Statement Depreciation			145			(145)		69
70	TOTAL (lines 4 thru 69)		$ 170,114	$ 7,453		$ 1,221	$ (6,232)	$ 6,832	70

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

Facility Name & ID Number Blue Island Nursing Home # 0035394 Report Period Beginning: 01/01/04 Ending: 12/31/04

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		$ 170,114	$ 7,453		$ 1,221	$ (6,232)	$ 6,832	1
2	Heating & Cooling Unit	2002	5,650		20	471	471	1,295	2
3	Water Heater	2002	3,475		20	290	290	845	3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 179,239	$ 7,453		$ 1,982	$ (5,471)	$ 8,972	34

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

Facility Name & ID Number Blue Island Nursing Home # 0035394 Report Period Beginning: 01/01/04 Ending: 12/31/04

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	$ 78,239	$ 4,071	$ 8,458	$ 4,387	10	$ 42,490	71
72	Current Year Purchases							72
73	Fully Depreciated Assets	967				10	967	73
74								74
75	TOTALS	$ 79,206	$ 4,071	$ 8,458	$ 4,387		$ 43,457	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)	$ 277,291	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 11,524	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 10,440	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (1,084)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 52,429	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.

Facility Name & ID Number Blue Island Nursing Home # 0035394 Report Period Beginning: 01/01/04 Ending: 12/31/04

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. [X] YES [ ] NO

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

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: [ ] YES [ ] NO Terms: *

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.	/2005	$
13.	/2006	$
14.	/2007	$

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

15. Is Movable equipment rental included in building rental? [X] YES [ ] NO

16. Rental Amount for movable equipment: $ 1,068 Description: See Attached Schedule
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	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 Blue Island Nursing Home # 0035394 Report Period Beginning: 1/1/2004 Ending: 12/31/2004

Supplemental Schedule of Equipment Rental

12/31/2004

	Description	Amount
16A	Air Saver	1,068
16B		
16C		
16D		
16E		
16F		
16G		
16H		
16I		
16J		
16K		
16L		
16M		
16N		
16O		
16P		
16Q		
16R		
16S		
16T		
	Total	1,068

Facility Name & ID Number Blue Island Nursing Home # 0035394 Report Period Beginning: 01/01/04 Ending: 12/31/04

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

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

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		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	Nurse Aide 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 aides from other facilities.

$

D. NUMBER OF AIDES 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 aide 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 aides.
(e) The total amount of Drop-out and Completed Costs for your own aides 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 aides.

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

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			$		$	$		$	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 nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number Blue Island Nursing Home # 0035394 **Report Period Beginning:** 01/01/04 **Ending:** 12/31/04

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 12/31/04 **(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	$ 822	$ 822	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	188,914	188,914	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Attached Schedule	9,607	10,607	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 199,343	$ 200,343	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		44,037	13
14	Buildings, at Historical Cost		285,000	14
15	Leasehold Improvements, at Historical Cost	9,125	9,125	15
16	Equipment, at Historical Cost	10,488	55,488	16
17	Accumulated Depreciation (book methods)	(14,356)	(106,591)	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): See Attached Schedule	56,773	56,773	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 62,030	$ 343,832	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 261,373	$ 544,175	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 133,371	$ 154,015	26
27	Officer's Accounts Payable	382,122	382,122	27
28	Accounts Payable-Patient Deposits	15,613	15,613	28
29	Short-Term Notes Payable	71,879	71,879	29
30	Accrued Salaries Payable	21,058	21,058	30
31	Accrued Taxes Payable (excluding real estate taxes)	2,537	2,537	31
32	Accrued Real Estate Taxes(Sch.IX-B)	29,000	29,000	32
33	Accrued Interest Payable		1,226	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached Schedule	46,741	46,741	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 702,321	$ 724,191	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		262,044	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)**	$	$ 262,044	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 702,321	$ 986,235	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (440,948)	$ (442,060)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 261,373	$ 544,175	48

***(See instructions.)**

Facility Name & ID Number Blue Island Nursing Home # 0035394 Report Period Beginning: 1/1/2004 Ending: 12/31/2004

Supplemental Schedule of Other Assets and Liabilities

As of 12/31/04

	Other Current Assets:	Amount	Amount
09A	RE Tax Escrow	9,607	10,607
09B			
09C			
09D			
09E			
09F			
09G			
		9,607	10,607

	Other Current Liabilities:	Amount	Amount
36A	Due To Others	23,500	23,500
36B	Due To IRS	12,044	12,044
36C	Due To IDOR	1,705	1,705
36D	Insurance Payable	5,352	5,352
36E	Illinois Assessment Tax Payable	4,140	4,140
36F			
36G			
		46,741	46,741

	Other Non-Current Assets:	Amount	Amount
23A	Construction In Progress	24,273	24,273
23B	Covenant Not To Compete - Noncash	32,500	32,500
23C			
23D			
23E			
23F			
23G			
		56,773	56,773

	Other Non-Current Liabilities:
43A	
43B	
43C	
43D	
43E	
43F	
43G	

Facility Name & ID Number Blue Island Nursing Home # 0035394 Report Period Beginning: 01/01/04 Ending: 12/31/04

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (376,970)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (376,970)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(63,978)	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)**	$ (63,978)	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)**	$ (440,948)	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number Blue Island Nursing Home # 0035394 Report Period Beginning: 01/01/04 Ending: 12/31/04

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.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 660,568	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 660,568	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	Nurses Aide 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***		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$	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)**	$ 660,568	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	130,688	31
32	Health Care	302,529	32
33	General Administration	163,062	33
	B. Capital Expense		
34	Ownership	111,797	34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee	16,470	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 724,546	40
41	**Income before Income Taxes (line 30 minus line 40)****	(63,978)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (63,978)	43

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

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

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

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

Facility Name & ID Number Blue Island Nursing Home # 0035394 Report Period Beginning: 01/01/04 Ending: 12/31/04

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	942	982	$ 20,000	$ 20.37	1
2	Assistant Director of Nursing					2
3	Registered Nurses	2,315	2,372	39,009	16.45	3
4	Licensed Practical Nurses	6,736	6,972	113,713	16.31	4
5	Nurse Aides & Orderlies	12,001	12,195	83,175	6.82	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	2,082	2,117	27,660	13.07	10
11	Social Service Workers					11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	2,101	2,312	20,245	8.76	15
16	Dishwashers					16
17	Maintenance Workers					17
18	Housekeepers	3,526	3,752	26,299	7.01	18
19	Laundry					19
20	Administrator	526	526	10,750	20.44	20
21	Assistant Administrator	1,651	1,651	40,746	24.68	21
22	Other Administrative	1,256	1,256	20,800	16.56	22
23	Office Manager					23
24	Clerical					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					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	33,136	34,135	$ 402,397 *	$ 11.79	34

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

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	71	$ 1,000	01-03	35
36	Medical Director				36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	15	540	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	23	1,194	11-03	44
45	Social Service Consultant	60	3,163	12-03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	169	$ 5,897		49

C. CONTRACT NURSES

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

Facility Name & ID Number Blue Island Nursing Home # 0035394 Report Period Beginning: 01/01/04 Ending: 12/31/04

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Zohar Hochenbaum	Administrator	50%	$ 10,750
Rita Hochenbaum	Administrative	0	8,400
Ester Perl	Administrative	0	8,400
Jonathan Perl	Administrative	0	2,000
Rami Hochenbaum	Administrative	0	2,000
Gwendolyn Crowder	Asst Administrator	0	39,146
Rosemarie Merrill	Asst Administrator	0	1,600
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 72,296

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$

C. Professional Services

Vendor/Payee	Type	Amount
Tenney & Bentley	Legal	$ 720
Rock, Fusco & Garvey	Legal	1,879
FR&R	Accounting	11,566
Payroll Processing Fees	Data Processing	3,369
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $2500 attach copy of invoices.)		$ 17,534

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 5,352
Unemployment Compensation Insurance	8,830
FICA Taxes	30,784
Employee Health Insurance	
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
TOTAL (agree to Schedule V, line 22, col.8)	$ 44,966

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	
Health Care Worker Background Check	
(Indicate # of checks performed 27)	228
Advertising and Promotions	683
Licenses and Fees	620
Less: Public Relations Expense	( )
Non-allowable advertising	(683)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 848

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	500
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 500

**See instructions.

Facility Name & ID Number Blue Island Nursing Home # 0035394 Report Period Beginning: 01/01/04 Ending: 12/31/04

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	Amount of Expense Amortized Per Year								
					FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009
1	N/A		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Blue Island Nursing Home # 0035394 **Report Period Beginning:** 01/01/04 **Ending:** 12/31/04

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(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 Years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ Line **10-02**

(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 of Public Aid during this cost report period. $ **16,470**
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 of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **N/A**

(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. $ 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? **N/A**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
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. $

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **N/A**
Attach invoices and a summary of services for all architect and appraisal fees.

Blue Island Nursing Home, inc.
LEGAL SERVICES
01/01/04 - 12/31/04

DATE	G/L ACCT #	PAYEE/VENDOR	AMOUNT
3/1/2004		Tenney & Bentley	$231.20
4/5/2004		Tenney & Bentley	$140.00
12/28/2004		Tenney & Bentley	$348.41
8/23/2004		Rock, Fusco & Garvey	$1,879.44
	TOTAL		**$2,599.05**