

		FOR OHF USE					

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**2001  
STATE OF ILLINOIS  
DEPARTMENT OF PUBLIC AID  
FINANCIAL AND STATISTICAL REPORT FOR  
LONG-TERM CARE FACILITIES  
(FISCAL YEAR 2001)**

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

<p><b>I. IDPH Facility ID Number:</b> <u>0026484</u></p> <p><b>Facility Name:</b> <u>LAKEVIEW NURSING &amp; REHAB CTRE</u></p> <p><b>Address:</b> <u>735 W. DIVERSEY</u> <u>CHICAGO</u> <u>60614</u>  <small>Number City Zip Code</small></p> <p><b>County:</b> <u>COOK</u></p> <p><b>Telephone Number:</b> <u>(847) 784-8204</u> Fax # <u>(847) 784-8248</u></p> <p><b>IDPA ID Number:</b> <u>36-3133316</u></p> <p><b>Date of Initial License for Current Owners:</b> <u>08/14/81</u></p> <p><b>Type of Ownership:</b></p> <table style="width:100%; border: none;"> <tr> <td style="width:33%; border: none;"><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td style="width:33%; border: none;"><input checked="" type="checkbox"/> PROPRIETARY</td> <td style="width:33%; border: none;"><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td style="border: none;"><input type="checkbox"/> Charitable Corp.</td> <td style="border: none;"><input type="checkbox"/> Individual</td> <td style="border: none;"><input type="checkbox"/> State</td> </tr> <tr> <td style="border: none;"><input type="checkbox"/> Trust</td> <td style="border: none;"><input type="checkbox"/> Partnership</td> <td style="border: none;"><input type="checkbox"/> County</td> </tr> <tr> <td style="border: none;"><b>IRS Exemption Code</b> _____</td> <td style="border: none;"><input type="checkbox"/> Corporation</td> <td style="border: none;"><input type="checkbox"/> Other _____</td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;"><input checked="" type="checkbox"/> "Sub-S" Corp.</td> <td style="border: none;"></td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;"><input type="checkbox"/> Limited Liability Co.</td> <td style="border: none;"></td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;"><input type="checkbox"/> Trust</td> <td style="border: none;"></td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;"><input type="checkbox"/> Other _____</td> <td style="border: none;"></td> </tr> </table> <p><b>In the event there are further questions about this report, please contact:</b>  <b>Name:</b> <u>BOB KAGDA</u> <b>Telephone Number:</b> <u>( 847 ) 675-3585</u></p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County	<b>IRS Exemption Code</b> _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input checked="" type="checkbox"/> "Sub-S" Corp.			<input type="checkbox"/> Limited Liability Co.			<input type="checkbox"/> Trust			<input type="checkbox"/> Other _____		<p><b>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</b></p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/2001</u> to <u>12/31/2001</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:15%; padding: 5px;">Officer or Administrator of Provider</td> <td style="padding: 5px;">(Signed) _____ (Date) _____ (Type or Print Name) <u>JOHN BERNARDI</u> (Title) <u>CFO</u></td> </tr> <tr> <td style="width:15%; padding: 5px;">Paid Preparer</td> <td style="padding: 5px;">(Signed) <u>(SEE ATTACHED ACCOUNTANTS' REPORT)</u> (Date) _____ (Print Name and Title) <u>BOB KAGDA</u> <u>PARTNER</u> (Firm Name &amp; Address) <u>KRUPNICK BOKOR KAGDA &amp; BROOKS, LTD</u> <u>3750 W DEVON AVE, LINCOLNWOOD, IL 60712-1124</u> (Telephone) <u>( 847 ) 675-3585</u> Fax # <u>( 847 ) 675-5777</u></td> </tr> </table> <p align="right">MAIL TO: OFFICE OF HEALTH FINANCE ILLINOIS DEPARTMENT OF PUBLIC AID 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630</p>	Officer or Administrator of Provider	(Signed) _____ (Date) _____ (Type or Print Name) <u>JOHN BERNARDI</u> (Title) <u>CFO</u>	Paid Preparer	(Signed) <u>(SEE ATTACHED ACCOUNTANTS' REPORT)</u> (Date) _____ (Print Name and Title) <u>BOB KAGDA</u> <u>PARTNER</u> (Firm Name & Address) <u>KRUPNICK BOKOR KAGDA &amp; BROOKS, LTD</u> <u>3750 W DEVON AVE, LINCOLNWOOD, IL 60712-1124</u> (Telephone) <u>( 847 ) 675-3585</u> Fax # <u>( 847 ) 675-5777</u>
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Facility Name & ID Number LAKEVIEW NURSING & REHAB CTRE# 0026484 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

## 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	63	Skilled (SNF)	63	22,995	1
2		Skilled Pediatric (SNF/PED)			2
3	117	Intermediate (ICF)	117	42,705	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	180	TOTALS	180	65,700	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				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF	16,458	1,206	479	18,143	8
9	SNF/PED					9
10	ICF	30,642	1,802	9,468	41,912	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	47,100	3,008	9,947	60,055	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 91.41%

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

1,094 (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)

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

G. Do pages 3 &amp; 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 08/14/81

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

YES  Date 08/14/81 NO 

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

YES  NO  If YES, enter number of beds certified 63 and days of care provided 9,468Medicare Intermediary ADMINASTAR

## IV. ACCOUNTING BASIS

ACCRUAL  MODIFIED CASH\*  CASH\* Is your fiscal year identical to your tax year? YES  NO Tax Year: 12/31/01 Fiscal Year: 12/31/01

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

Facility Name & ID Number LAKEVIEW NURSING & REHAB CTRE # 0026484 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

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 OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>A. General Services</b>										
1	Dietary	263,919	84,683	22,742	371,344		371,344	0	371,344		1
2	Food Purchase		230,918		230,918	(11,133)	219,785	0	219,785		2
3	Housekeeping	265,320	21,094	0	286,414		286,414	0	286,414		3
4	Laundry	88,173	17,886	2,489	108,548		108,548	0	108,548		4
5	Heat and Other Utilities			166,441	166,441		166,441	0	166,441		5
6	Maintenance	65,685	25,274	68,194	159,153		159,153	1,940	161,093		6
7	Other (specify):*			22,634	22,634		22,634	0	22,634		7
8	<b>TOTAL General Services</b>	683,097	379,855	282,500	1,345,452	(11,133)	1,334,319	1,940	1,336,259		8
	<b>B. Health Care and Programs</b>										
9	Medical Director	0		22,835	22,835		22,835	0	22,835		9
10	Nursing and Medical Records	2,395,242	92,693	148,043	2,635,978		2,635,978	0	2,635,978		10
10a	Therapy	243,380	46	0	243,426		243,426	0	243,426		10a
11	Activities	104,833	7,251	319	112,403		112,403	0	112,403		11
12	Social Services	88,341		4,200	92,541		92,541	0	92,541		12
13	Nurse Aide Training			0	0		0	0	0		13
14	Program Transportation			525	525		525	0	525		14
15	Other (specify):*				0		0	0	0		15
16	<b>TOTAL Health Care and Programs</b>	2,831,796	99,990	175,922	3,107,708	0	3,107,708	0	3,107,708		16
	<b>C. General Administration</b>										
17	Administrative	422,705		434,333	857,038		857,038	0	857,038		17
18	Directors Fees			0	0		0	0	0		18
19	Professional Services			310,089	310,089		310,089	0	310,089		19
20	Dues, Fees, Subscriptions & Promotions			82,192	82,192		82,192	(39,608)	42,584		20
21	Clerical & General Office Expenses	377,941	73,849	119,431	571,221		571,221	(34,579)	536,642		21
22	Employee Benefits & Payroll Taxes			656,448	656,448	11,133	667,581	0	667,581		22
23	Inservice Training & Education			10,639	10,639		10,639	0	10,639		23
24	Travel and Seminar			7,654	7,654		7,654	0	7,654		24
25	Other Admin. Staff Transportation			12,249	12,249		12,249	0	12,249		25
26	Insurance-Prop.Liab.Malpractice			105,960	105,960		105,960	0	105,960		26
27	Other (specify):*			365,583	365,583		365,583	(365,583)	0		27
28	<b>TOTAL General Administration</b>	800,646	73,849	2,104,578	2,979,073	11,133	2,990,206	(439,770)	2,550,436		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	4,315,539	553,694	2,563,000	7,432,233	0	7,432,233	(437,830)	6,994,403		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 (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>D. Ownership</b>											
30	Depreciation			104,831	104,831		104,831	26,790	131,621			30
31	Amortization of Pre-Op. & Org.			0	0		0	0	0			31
32	Interest			177,544	177,544		177,544	354,465	532,009			32
33	Real Estate Taxes			194,351	194,351		194,351	0	194,351			33
34	Rent-Facility & Grounds			587,666	587,666		587,666	(587,666)	0			34
35	Rent-Equipment & Vehicles			34,945	34,945		34,945	0	34,945			35
36	Other (specify):* <b>OFFICE RENT</b>			31,605	31,605		31,605	0	31,605			36
37	<b>TOTAL Ownership</b>			1,130,942	1,130,942	0	1,130,942	(206,411)	924,531			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation				0		0	0	0			38
39	Ancillary Service Centers		331,541	46,730	378,271		378,271	0	378,271			39
40	Barber and Beauty Shops				0		0	0	0			40
41	Coffee and Gift Shops				0		0	0	0			41
42	Provider Participation Fee			98,550	98,550		98,550	0	98,550			42
43	Other (specify):*				0		0	0	0			43
44	<b>TOTAL Special Cost Centers</b>	0	331,541	145,280	476,821	0	476,821	0	476,821			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	4,315,539	885,235	3,839,222	9,039,996	0	9,039,996	(644,241)	8,395,755			45

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

VI. ADJUSTMENT DETAIL

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

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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	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	20,828	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		2		13
14	Non-Care Related Interest	(7,736)	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)		25		16
17	Non-Care Related Fees	0	20		17
18	Fines and Penalties	(34,579)	21		18
19	Entertainment	(13,573)	20		19
20	Contributions	(9,513)	20		20
21	Owner or Key-Man Insurance	0	22		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(365,583)	27		24
25	Fund Raising, Advertising and Promotional	(11,820)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(4,702)	20		28
29	Other-Attach Schedule SEE PAGE 5A	1,940			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (424,738)		\$ 0	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	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)	(219,503)		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ (219,503)		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ (644,241)		37

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

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

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

STATE OF ILLINOIS  
LAKEVIEW NURSING & REHAB CTRE

ID# 0026484

Report Period Beginning: 01/01/2001

Ending: 12/31/2001

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	
1	DEFERRED MAINTENANCE	\$ 1940	6	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
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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	<b>Total</b>	1,940		48
49				49

## STATE OF ILLINOIS

Summary A

Facility Name &amp; ID Number LAKEVIEW NURSING &amp; REHAB CTRE

# 0026484

Report Period Beginning:

01/01/2001

Ending:

12/31/2001

## 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)	
	<b>A. General Services</b>													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	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	1,940	0	0	0	0	0	0	0	0	0	0	1,940	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	<b>TOTAL General Services</b>	<b>1,940</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>1,940</b>	<b>8</b>
	<b>B. Health Care and Programs</b>													
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	<b>TOTAL Health Care and Programs</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>16</b>
	<b>C. General Administration</b>													
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	(39,608)	0	0	0	0	0	0	0	0	0	0	(39,608)	20
21	Clerical & General Office Expenses	(34,579)	0	0	0	0	0	0	0	0	0	0	(34,579)	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):*	(365,583)	0	0	0	0	0	0	0	0	0	0	(365,583)	27
28	<b>TOTAL General Administration</b>	<b>(439,770)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(439,770)</b>	<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	<b>(437,830)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(437,830)</b>	<b>29</b>

STATE OF ILLINOIS

Summary B

Facility Name & ID Number LAKEVIEW NURSING & REHAB CTRE

# 0026484

Report Period Beginning:

01/01/2001 Ending:

12/31/2001

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	20,828	5,962	0	0	0	0	0	0	0	0	0	26,790	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(7,736)	362,201	0	0	0	0	0	0	0	0	0	354,465	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	(587,666)	0	0	0	0	0	0	0	0	0	(587,666)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	<b>TOTAL Ownership</b>	<b>13,092</b>	<b>(219,503)</b>	<b>0</b>	<b>(206,411)</b>	<b>37</b>								
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
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	<b>TOTAL Special Cost Centers</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>44</b>
45	<b>GRAND TOTAL COST</b> <b>(sum of lines 29, 37 &amp; 44)</b>	<b>(424,738)</b>	<b>(219,503)</b>	<b>0</b>	<b>(644,241)</b>	<b>45</b>								

**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
SAM BOREK	75			BOREK & GOLDBIRSH		
HILLARD GARLOVSKY	25				WILMETTE	LAW FIRM

**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: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V	34 RENT	\$ 587,666	735 WEST DIVERSEY BUILDING LLC		\$	(587,666)	1
2	V	30 SL DEPRECIATION				5,962	5,962	2
3	V	32 INTEREST				362,201	362,201	3
4	V							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		\$ 587,666			\$ 368,163	\$ * (219,503)	14

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

Facility Name & ID Number LAKEVIEW NURSING & REHAB CTRE # 0026484 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

## 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	SAM BOREK	PRESIDENT	ADMINISTRATIV	75.00	0	30	60.00	SALARY	\$ 241,473	17-1	1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 241,473		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 LAKEVIEW NURSING & REHAB CTRE

# 0026484

Report Period Beginning: 01/01/2001

Ending: 2/31/2001

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 735 WEST DIVERSEY BUILDING LLC  
 Street Address 735 WEST DIVERSEY  
 City / State / Zip Code CHICAGO, 60614  
 Phone Number ( 773) 349-4055  
 Fax Number ( 773) 348-0684

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	30	DEPRECIATION (SL)	DIRECT COST	1	1	\$ 5,962	\$	1	\$ 5,962	1
2	32	INTEREST	DIRECT COST	1	1	362,201		1	362,201	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					\$ 368,163	\$		\$ 368,163	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	2	3	4	5	6		8	9	10										
						Name of Lender	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
<b>A. Directly Facility Related</b>																				
<b>Long-Term</b>																				
1	RELATED PARTY						\$	\$			\$	1								
2	MANUFACTURER BANK		X	MORTGAGE	DEMAND	03/01	7,000,000	7,000,000		PRIME	362,201	2								
3												3								
4												4								
5												5								
<b>Working Capital</b>																				
6	SUCCESS BANK		X	WORKING CAPITAL	DEMAND	12/95	487,000	1,385,748		PRIME+	105,206	6								
7	SAM BOREK		X	WORKING CAPITAL				150,101			22,636	7								
8	HILLARD GORLOVSKY		X	WORKING CAPITAL				487,353			41,966	8								
9	TOTAL Facility Related						\$ 7,487,000	\$ 9,023,202			\$ 532,009	9								
<b>B. Non-Facility Related*</b>																				
10	IRS, IDR, ETC		X	LATE FEES							1,218	10								
11	AUTO LOAN		X								6,518	11								
12												12								
13												13								
14	TOTAL Non-Facility Related						\$ 0	\$ 0			\$ 7,736	14								
15	TOTALS (line 9+line14)						\$ 7,487,000	\$ 9,023,202			\$ 539,745	15								

\* 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 LAKEVIEW NURSING & REHAB CTRE# 0026484 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

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

## B. Real Estate Taxes

1. Real Estate Tax accrual used on 2000 report.		<b>Important</b> , please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	\$	<b>176,500</b>	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.)			\$	<b>183,591</b>	2																			
3. Under or (over) accrual (line 2 minus line 1).			\$	<b>7,091</b>	3																			
4. Real Estate Tax accrual used for 2001 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	<b>187,260</b>	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. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>			\$		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. <b>TOTAL REFUND \$ _____ For 19 _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>			\$		6																			
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.			\$	<b>194,351</b>	7																			
Real Estate Tax History:																								
Real Estate Tax Bill for Calendar Year:																								
1996	<u>172,890</u>	<u>8</u>	<table border="1"> <thead> <tr> <th colspan="3">FOR OHF USE ONLY</th> </tr> </thead> <tbody> <tr> <td>13</td> <td>FROM R. E. TAX STATEMENT FOR 2000</td> <td>\$</td> <td>13</td> </tr> <tr> <td>14</td> <td>PLUS APPEAL COST FROM LINE 5</td> <td>\$</td> <td>14</td> </tr> <tr> <td>15</td> <td>LESS REFUND FROM LINE 6</td> <td>\$</td> <td>15</td> </tr> <tr> <td>16</td> <td>AMOUNT TO USE FOR RATE CALCULATION</td> <td>\$</td> <td>16</td> </tr> </tbody> </table>			FOR OHF USE ONLY			13	FROM R. E. TAX STATEMENT FOR 2000	\$	13	14	PLUS APPEAL COST FROM LINE 5	\$	14	15	LESS REFUND FROM LINE 6	\$	15	16	AMOUNT TO USE FOR RATE CALCULATION	\$	16
FOR OHF USE ONLY																								
13	FROM R. E. TAX STATEMENT FOR 2000	\$				13																		
14	PLUS APPEAL COST FROM LINE 5	\$				14																		
15	LESS REFUND FROM LINE 6	\$				15																		
16	AMOUNT TO USE FOR RATE CALCULATION	\$	16																					
1997	<u>172,872</u>	<u>9</u>																						
1998	<u>175,941</u>	<u>10</u>																						
1999	<u>174,760</u>	<u>11</u>																						
2000	<u>183,591</u>	<u>12</u>																						
<b>THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED ON ~ 102% OF THE PRIOR YEAR REAL ESTATE TAX BILL.</b>																								
<b>THE PAYMENT ON LINE 2 APPLIES TO THE 2000 TAX BILL.</b>																								

## NOTES:

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

**IMPORTANT NOTICE**

TO: Long Term Care Facilities with Real Estate Tax Rates RE: 2000 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 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 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 2001 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,

**2000 LONG TERM CARE REAL ESTATE TAX STATEMENT**

FACILITY NAME LAKEVIEW NURSING & REHAB CTRE COUNTY COOK

FACILITY IDPH LICENSE NUMBER 0026484

CONTACT PERSON REGARDING THIS REPORT BOB KAGDA

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

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

Enter the tax index number and real estate tax assessed for 2000 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 2000

(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>14-28-300-013-0000</u>	<u>NURSING HOME</u>	<u>\$ 183590.57</u>	<u>\$ 183,590.57</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		<u>\$ 0.00</u>	<u>\$ 183,590.57</u>

**B. Real Estate Tax Cost Allocation:**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not direct used for nursing home services?        YES        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 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 46,604 B. General Construction Type: Exterior BRICK Frame BRICK & STEEL 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, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

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

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

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

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1		0		\$	1
2					2
3	TOTALS			\$ 0	3

Facility Name &amp; ID Number LAKEVIEW NURSING &amp; REHAB CTRE

# 0026484

Report Period Beginning:

01/01/2001

Ending:

12/31/2001

## 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	180		2001		\$ 5,580,369	\$ 5,962	39	\$ 5,962	\$	\$ 5,962	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9		LEASEHOLD IMPROVEMENTS		1982	2,850					2,850	9
10		LEASEHOLD IMPROVEMENTS		1983	2,500		15			2,500	10
11		LEASEHOLD IMPROVEMENTS		1985	2,312		10			2,312	11
12		LEASEHOLD IMPROVEMENTS		1985	3,200		20	160	160	2,480	12
13		LEASEHOLD IMPROVEMENTS		1987	29,042	922	20	1,452	530	20,118	13
14		LEASEHOLD IMPROVEMENTS		1987	8,647	274	31.5	274		3,848	14
15		LEASEHOLD IMPROVEMENTS		1988	13,520	429	31.5	429		5,926	15
16		LEASEHOLD IMPROVEMENTS		1989	17,460	554	5	0	(554)	17,460	16
17		LEASEHOLD IMPROVEMENTS		1989	6,534	207	15	436	229	5,398	17
18		LEASEHOLD IMPROVEMENTS		1990	20,612	654	31.5	654		7,848	18
19		LEASEHOLD IMPROVEMENTS		1991	40,916	1,299	31.5	1,299		13,639	19
20		LEASEHOLD IMPROVEMENTS		1992	40,819	1,296	31.5	1,296		12,380	20
21		LEASEHOLD IMPROVEMENTS		1993	10,482	333	31.5	333		2,942	21
22		LEASEHOLD IMPROVEMENTS		1993	16,965	422	39	422		3,589	22
23		LEASEHOLD IMPROVEMENTS		1994	9,602	239	39	239		1,911	23
24		ROOF REPAIR		1995	3,188	79	39	79		544	24
25		SHOWER RECONSTRUCTION		1995	7,775	194	39	194		1,214	25
26		SHOWER ROOMS RENOVATION		1996	35,634	888	39	888		5,163	26
27		OFFICE CONSTRUCTION		1996	4,647	116	39	116		654	27
28		ELECTRIC SLIDING DOOR		1996	1,380	34	39	34		183	28
29		BRICKWORK/TUCKPOINT		1997	1,680	42	39	42		204	29
30		PARKING LOT		1997	1,900	47	15	47		333	30
31		CLOSET WORK		1997	800	20	39	20		97	31
32		CONSULTING AND INSTALL FIREDOORS		1997	23,621	589	39	589		2,529	32
33		FIRE ALARM PANEL		1998	3,500	88	39	88		345	33
34		ROOF EXHAUST FANS, INSTALLATION FIRE DAMPERS		1998	20,698	519	39	519		1,990	34
35		FRONT PORCH ENTRANCE, ONE MARGUEE CANOPY		1998	2,247	58	39	58		203	35
36		SMOKE DAMPERS		1998	1,669	43	39	43		145	36

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

See Page 12A, Line 70 for total

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

Facility Name &amp; ID Number LAKEVIEW NURSING &amp; REHAB CTRE

# 0026484

Report Period Beginning:

01/01/2001 Ending: 12/31/2001

## 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	WALK IN FREEZER-NEW CONDENSING UNIT	1998	\$ 5,546	\$ 142	39	\$ 142	\$	\$ 456	37
38	CEILING & LIGHT FIXTURES, ELECTRICAL	1998	30,226	775	39	775		2,359	38
39	CAFETERIAS - 1ST AND 3RD FLOOR	1999	3,000	77	39	77		221	39
40	LIGHTING, ELECTRICAL WORK, INSTALL CABLE	1999	27,482	705	39	705		2,004	40
41	DOORS REPAIR & PAINT-1ST, 2ND AND 3RD FLOOR	1999	25,070	643	39	643		1,714	41
42	PLUMBING ROUGH	1999	10,300	264	39	264		715	42
43	PAINT WORK-1ST, 2ND, 3RD FLOOR, BASEMENT	1999	21,014	539	39	539		1,325	43
44	WALLCOVERING, CARPET TILES	1999	55,627	1,426	39	1,426		3,551	44
45	GENERATOR EXHAUST PIPE	1999	2,300	59	39	59		155	45
46	HANDRAILS -1ST, 2ND, 3RD FLOOR, BASEMENT	1999	24,340	624	39	624		1,610	46
47	ALARM SYSTEM	1999	107,758	2,763	39	2,763		7,663	47
48	DINING ROOM - 2ND AND 3RD FLOOR	1999	12,206	313	39	313		772	48
49	SHOWER AND FRONT STOOP REPAIR	1999	4,300	110	39	110		264	49
50	WINDOWS, CLOSETS, EXTERIOR	1999	4,415	113	39	113		187	50
51	INSTALLATION OF THE FIRE DAMPERS	1999	5,880	151	39	151		434	51
52	CANVAS CANOPY	2000	3,996	102	39	102		185	52
53	INSTALLATION OF COOLING TOWER	2000	24,450	627	39	627		1,070	53
54	ALARM SYSTEM- ADDITIONAL PROTECTION	2000	1,970	51	39	51		87	54
55	DIALYSIS ROOM EXTRA CIRCUITS	2000	1,983	51	39	51		87	55
56	MICROLIGHT DETECTORS	2000	3,800	97	39	97		146	56
57	REPAIR DRYWALL	2000	3,744	96	39	96		121	57
58	ELECTRICAL PANEL FOR DIALYSIS CENTER	2000	2,380	61	39	61		74	58
59	INSTALLED 9 DOOR HOLDERS	2000	3,465	89	39	89		100	59
60	PLEATED SHADES	2000	949	422	20	47	(375)	94	60
61	REMODELING NEW NORTHFIELD OFFICE	2001	3,440	85	39	85		85	61
62	TWO PASSENGER ELEVATOR	2001	84,711	815	39	815		815	62
63	TUCKPOINTING	2001	3,160	17	39	17		17	63
64	REPAVE DRIVEWAY & PARKING LOT	2001	7,000	61	39	61		61	64
65	ELECTRICAL WORK	2001	11,922	49	39	49		49	65
66	ROOF REPAIR	2001	7,945	57	39	57		57	66
67	PAINTING, WALLPAPERING, DRYWALL	2001	42,598	693	39	693		693	67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 6,461,546	\$ 27,385		\$ 27,375	\$ (10)	\$ 151,938	70

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

Facility Name & ID Number LAKEVIEW NURSING & REHAB CTRE # 0026484 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

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	\$ 628,873	\$ 51,169	\$ 70,967	\$ 19,798	3-20	\$ 387,186	71
72	Current Year Purchases	60,488	10,966	4,793	(6,173)	3-10	4,793	72
73	Fully Depreciated Assets	222,413			0		222,413	73
74					0			74
75	TOTALS	\$ 911,774	\$ 62,135	\$ 75,760	\$ 13,625		\$ 614,392	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		1993 MERSEDES	1995	\$ 50,067	\$ 1,775		\$ (1,775)		\$ 50,067	76
77		1999 BLAZER/PARCHE	1999	71,351	5,900	17,838	11,938	4	53,514	77
78		JEEP/NISSAN/PARTHFIN.	1999	37,812	2,950		(2,950)		37,812	78
79		1999 MERSEDES	2001	53,242	10,648	10,648	0	5	10,648	79
80	TOTALS			\$ 212,472	\$ 21,273	\$ 28,486	\$ 7,213		\$ 152,041	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)	\$ 7,585,792	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 110,793	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 131,621	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 20,828	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 918,371	85

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

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

G. Construction-in-Progress

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

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

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

**XII. RENTAL COSTS**

**A. Building and Fixed Equipment (See instructions.)**

1. Name of Party Holding Lease: N/A

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

If NO, see instructions.  YES  NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	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	<b>TOTAL</b>				\$			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.	<u>/2002</u>	\$ _____
13.	<u>/2003</u>	\$ _____
14.	<u>/2004</u>	\$ _____

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: \$ 23,275 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>ADMINISTRATIVE</u>	<u>2000 VOLVO</u>	\$ <u>535.00</u>	\$ <u>7,487</u>	17
18	<u>ADMINISTRATIVE</u>	<u>2000 MERCEDES BENZ</u>	\$ <u>1,394.00</u>	\$ <u>4,183</u>	18
19					19
20					20
21	<b>TOTAL</b>		\$ <b>1,929.00</b>	\$ <b>11,670</b>	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 LAKEVIEW NURSING & REHAB CTRE # 0026484 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

**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.)**

<p>1. HAVE YOU TRAINED AIDES 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 AIDE _____</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 AIDE _____</p>
------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	-------------------------------------------------------------------------------------------------------------------------------------------------------------------

**B. EXPENSES**

**ALLOCATION OF COSTS (d)**

		Facility		3	4
		1	2		
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$ 0
2	Books and Supplies				0
3	Classroom Wages (a)				0
4	Clinical Wages (b)				0
5	In-House Trainer Wages (c)				0
6	Transportation				0
7	Contractual Payments				0
8	Nurse Aide Competency Tests				0
9	TOTALS	\$ 0	\$ 0	\$ 0	\$ 0
10	SUM OF line 9, col. 1 and 2 (e)	\$ 0			

**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)	
<b>TOTAL TRAINED</b>	

- (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.)

	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	39-3	hrs			33,971			33,971	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescripts				269,635		269,635	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Medical Supplies/Laboratory/Rentals Other (specify): <u>Respiratory Therapy</u>	39-2 39-3				3,876	70,789		70,789 3,876	13
14	TOTAL			\$		\$ 37,847	\$ 340,424		\$ 378,271	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 &amp; ID Number LAKEVIEW NURSING &amp; REHAB CTRE

# 0026484

Report Period Beginning: 01/01/2001

Ending:

12/31/2001

## XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2001 (last day of reporting year)

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

		1 Operating	2 After Consolidation*	
<b>A. Current Assets</b>				
1	Cash on Hand and in Banks	\$ 14,730	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance )	1,844,852		3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	47,480		6
7	Other Prepaid Expenses	5,817		7
8	Accounts Receivable (owners or related parties)	377,259		8
9	Other(specify): <u>Real Estate Tax Escrow,Ins</u>	154,269		9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 2,444,407	\$ 0	10
<b>B. Long-Term Assets</b>				
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	881,177		15
16	Equipment, at Historical Cost	1,124,246		16
17	Accumulated Depreciation (book methods)	(967,195)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	177,219		21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <u>SECURITY DEPOSITS</u>	2,600		23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 1,218,047	\$ 0	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 3,662,454	\$ 0	25

		1 Operating	2 After Consolidation*	
<b>C. Current Liabilities</b>				
26	Accounts Payable	\$ 1,519,122	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	13,507		28
29	Short-Term Notes Payable	1,462,754		29
30	Accrued Salaries Payable	216,754		30
31	Accrued Taxes Payable (excluding real estate taxes)	10,334		31
32	Accrued Real Estate Taxes(Sch.IX-B)	187,260		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
<b>Other Current Liabilities(specify):</b>				
36				36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 3,409,731	\$ 0	38
<b>D. Long-Term Liabilities</b>				
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
<b>Other Long-Term Liabilities(specify):</b>				
43				43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$ 0	\$ 0	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 3,409,731	\$ 0	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 252,723	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 3,662,454	\$ 0	48

\*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 241,132	1
2	Restatements (describe):		2
3	PRIOR YEAR ADJUSTMENT	(7,057)	3
4	IL PERLACEMENT TAX	(1,023)	4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 233,052	6
	<b>A. Additions (deductions):</b>		
7	NET Income (Loss) (from page 19, line 43)	19,671	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)	\$ 19,671	17
	<b>B. Transfers (Itemize):</b>		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$ 0	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 252,723	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	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 8,988,944	1
2	Discounts and Allowances for all Levels	( )	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 8,988,944	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	68,255	6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 68,255	8
<b>C. Other Operating Revenue</b>			
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	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 0	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***		25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 0	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<b>VENDING COMMISSIONS</b>	2,468	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 2,468	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 9,059,667	30

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	1,345,452	31
32	Health Care	3,107,708	32
33	General Administration	2,979,073	33
<b>B. Capital Expense</b>			
34	Ownership	1,130,942	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	378,271	35
36	Provider Participation Fee	98,550	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 9,039,996	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	19,671	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 19,671	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 NOT YET PREPARED**

\*\*\* 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 LAKEVIEW NURSING & REHAB CTRE

# 0026484

Report Period Beginning:

01/01/2001

Ending:

12/31/2001

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	2,573	3,165	\$ 83,375	\$ 26.34	1
2	Assistant Director of Nursing	990	1,063	28,116	26.45	2
3	Registered Nurses	29,833	33,419	735,886	22.02	3
4	Licensed Practical Nurses	20,736	23,061	394,118	17.09	4
5	Nurse Aides & Orderlies	97,719	109,343	958,938	8.77	5
6	Nurse Aide Trainees					6
7	Licensed Therapist	3,901	4,121	87,907	21.33	7
8	Rehab/Therapy Aides	8,751	9,642	128,887	13.37	8
9	Activity Director	2,032	2,142	35,064	16.37	9
10	Activity Assistants	8,479	9,265	69,769	7.53	10
11	Social Service Workers	5,992	6,632	88,341	13.32	11
12	Dietician					12
13	Food Service Supervisor	2,041	2,112	35,859	16.98	13
14	Head Cook					14
15	Cook Helpers/Assistants	29,504	31,544	228,060	7.23	15
16	Dishwashers					16
17	Maintenance Workers	4,716	4,867	65,685	13.50	17
18	Housekeepers	34,355	36,190	265,320	7.33	18
19	Laundry	12,558	13,279	88,173	6.64	19
20	Administrator	3,819	4,758	379,947	79.85	20
21	Assistant Administrator	1,696	2,135	42,758	20.03	21
22	Other Administrative					22
23	Office Manager	1,936	2,445	77,888	31.86	23
24	Clerical	8,177	9,532	181,475	19.04	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	3,750	3,925	40,818	10.40	31
32	Other Health Care(specify)					32
33	Other(specify) SEE ATTACHED	20,648	22,628	299,155	13.22	33
34	TOTAL (lines 1 - 33)	304,206	335,268	\$ 4,315,539 *	\$ 12.87	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	\$ 20,108	1-3	35
36	Medical Director	O	22,835	9-3	36
37	Medical Records Consultant	N	8,064	10-3	37
38	Nurse Consultant	T	0	10-3	38
39	Pharmacist Consultant	H	0	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	319	11-3	44
45	Social Service Consultant	E	4,200	12-3	45
46	Other(specify) <u>NEUROLOGICAL</u>	S	3,000	10-3	46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 58,526		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	3,318	\$ 132,728	10-3	50
51	Licensed Practical Nurses	62	1,862	10-3	51
52	Nurse Aides	119	2,389	10-3	52
53	TOTAL (lines 50 - 52)	3,499	\$ 136,979		53



Facility Name & ID Number LAKEVIEW NURSING & REHAB CTRE

Report Period Beginning: 01/01/2001 Ending:

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

	1 Improvement Type	2 Month & Year Improvement Was Made	3 Total Cost	4 Useful Life	5-13 Amount of Expense Amortized Per Year								
					5 FY1998	6 FY1999	7 FY2000	8 FY2001	9 FY2002	10 FY2003	11 FY2004	12 FY2005	13 FY2006
1	PAINT/DECORATING	1998	\$ 10,667	3	\$ 1,778	\$ 3,556	\$ 3,556	\$ 1,777	\$	\$	\$	\$	\$
2	PAINT/DECORATING	1999	2,221	3		370	740	740	371				
3	PAINT/DECORATING	2000	3,515	3			587	1,171	1,171	586			
4	PAINT/DECORATING	2001	2,097	3				349	699	699	350		
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$ 18,500		\$ 1,778	\$ 3,926	\$ 4,883	\$ 4,037	\$ 2,241	\$ 1,285	\$ 350	\$	\$

Facility Name &amp; ID Number LAKEVIEW NURSING &amp; REHAB CTRE

**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? YES
- (2) Are there any dues to nursing home associations included on the cost report? YES  
If YES, give association name and amount. IL COUNCIL LONG TERM CARE \$4705
- (3) Did the nursing home make political contributions or payments to a political action organization? YES If YES, have these costs been properly adjusted out of the cost report? YES
- (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. \$ 7,080 Line 10-2
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? NO  
If YES, give effective date of lease. \_\_\_\_\_
- (9) Are you presently operating under a sublease agreement? \_\_\_\_\_ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES \_\_\_\_\_ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.  
\_\_\_\_\_
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 98,550  
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? 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. \$ 11,133 Has any meal income been offset against related costs? \_\_\_\_\_ Indicate the amount. \$ \_\_\_\_\_
- (16) Travel and Transportation  
a. Are there costs included for out-of-state travel? NO  
If YES, attach a complete explanation.  
b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such a program during this reporting period. \$ \_\_\_\_\_  
c. What percent of all travel expense relates to transportation of nurses and patients? 5%  
d. Have vehicle usage logs been maintained? NO  
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? NO  
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? YES  
**g. Does the facility transport residents to and from day training?** NO  
**Indicate the amount of income earned from providing such transportation during this reporting period.** \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? NO  
Firm Name: \_\_\_\_\_ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? \_\_\_\_\_ If no, please explain. \_\_\_\_\_
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? YES
- (19) If total legal fees are in excess of \$2500, 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.

V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE	SCHED REF	TOTAL
<b>1</b>	<b>DIETARY</b>	
	DIETITIAN CONSULTANT XVIII B 35-2	20,108
	REPAIRS & MAINTENANCE	2,634
		0
		22,742
<b>3</b>	<b>HOUSEKEEPING</b>	
		0
		0
		0
<b>4</b>	<b>LAUNDRY</b>	
	EQUIPMENT REPAIRS & MAINTENANCE	2,489
		0
		2,489
<b>5</b>	<b>HEAT &amp; OTHER UTILITIES</b>	
	GAS HEAT	82,758
	ELECTRICITY	62,922
	WATER	19,073
	CABLE TV - LOBBY	1,688
		0
		166,441
<b>6</b>	<b>MAINTENANCE</b>	
	GROUNDS MAINTENANCE	385
	PAINTING & DECORATING	2,097
	BUILDING REPAIRS	5,090
	MAINTENANCE TRAVEL	0
	EQUIPMENT MAINTENANCE & REPAIR	33,206
	ELEVATOR MAINTENANCE & REPAIR	9,456
	OUTSIDE LABOR	7,460
	EXTERMINATING SERVICE	6,048
	FIRE SERVICE	4,452
		0
		0
		0
		68,194
<b>7</b>	<b>OTHER</b>	
	SCAVENGER	15,270
	SECURITY SERVICE	7,364
		22,634
<b>9</b>	<b>MEDICAL DIRECTOR</b>	
	MEDICAL DIRECTOR FEES XVIII B 36-2	22,835
		22,835

LINE	SCHED REF	TOTAL
<b>10</b>	<b>NURSING</b>	
	CONTRACT NURSING XVIII C 53-2	136,979
	LABORATORY & XRAY EXPENSE	0
	PURCHASED SERVICES	0
	PSYCHO-SOCIAL CONSULTANT XVIII B -2	0
	RESTORATIVE NURSING CONSULTAN XVIII B 38-2	0
	MEDICAL RECORDS CONSULTANT XVIII B 37-2	8,064
	PHARMACY CONSULTANT XVIII B 39-2	0
	UTILIZATION REVIEW FEES XVIII B -2	0
	PHYSICIANS XVIII B -2	0
	PSYCHIATRIC XVIII B -2	0
	RN CONSULTANT XVIII B 38-2	0
	NEUROLOGICAL CONSULTANT	3,000
		0
		148,043
<b>10a</b>	<b>THERAPY</b>	
	PHYSICAL THERAPY SERVICES	0
	SPEECH THERAPY SERVICES	0
	OCCUPATIONAL THERAPY SERVICES	0
	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
		0
		0
<b>11</b>	<b>ACTIVITIES</b>	
	CABLE TV - PATIENT ROOMS	0
	ACTIVITY REHAB CONSULTANT XVIII B 44-2	319
		0
		319
<b>12</b>	<b>SOCIAL SERVICES</b>	
	SOCIAL REHABILITATION SERVICES	0
	SOCIAL REHABILITATION CONSULTAN XVIII B 45-2	0
	SOCIAL WORKER XVIII B 45-2	4,200
		0
		4,200
<b>13</b>	<b>NURSE AIDE TRAINING</b>	
	NURSE AIDE TRAINING COSTS XIII	0
		0

V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE	SCHED REF	TOTAL
14	<b>PROGRAM TRANSPORTATION</b>	
	PATIENT TRANSPORTATION	525
17	<b>ADMINISTRATIVE</b>	
	MANAGEMENT FEES XIX B	434,333
18	<b>DIRECTORS FEES</b>	0
19	<b>PROFESSIONAL SERVICES</b>	
	DATA PROCESSING XIX C	6,428
	ADMINISTRATIVE CONSULTANTS XIX C	0
	PROFESSIONAL FEES XIX C	303,661
		0
20	<b>FEES,SUBSCRIPTIONS,PROMOTIONS</b>	310,089
	ENTERTAINMENT & MARKETING VI 19 XIX F	13,573
	ADV & PROMO-NON PATIENT RELATED VI 25 XIX F	3,296
	EMPLOYEE WANT ADS XIX F	21,407
	CONTRIBUTIONS VI 20 XIX F	3,360
	DUES & SUBSCRIPTIONS XIX F	16,174
	LICENSES & PERMITS XIX F	3,315
	PUBLIC RELATIONS-PATIENT RELATED XIX F	8,524
	ADVERTISING-YELLOW PAGES VI 28 XIX F	4,702
	TRUST FEES / FRANCHISE TAX / ETC VI 17 XIX F	0
	CONTRIBUTIONS - POLITICAL VI 20 XIX F	6,153
	HEALTH CARE WORKER BACKGROUND CHEC XIX F	1,688
21	<b>CLERICAL &amp; GENERAL OFFICE EXPENSES</b>	82,192
	BANK CHARGES	4,092
	EQUIPMENT REPAIR & MAINTENANCE	10,544
	OUTSIDE CLERICAL SERVICES	1,490
	PENALTIES / OVERDRAFT CHARGES VI 18	34,579
	HOME OFFICE EXPENSE	0
	THEFT & DAMAGE LOSS	0
	TELEPHONE	65,302
	MESSENGER SERVICE	3,424
		0
		119,431

LINE	SCHED REF	TOTAL
22	<b>EMPLOYEE BENEFITS &amp; PAYROLL TAXES</b>	
	FICA TAXES XIX D	314,259
	UNEMPLOYMENT COMPENSATION XIX D	29,354
	WORKERS COMPENSATION INSURANC XIX D	56,890
	HOSPITALIZATION INSURANCE XIX D	213,958
	EMPLOYEE BENEFITS - OTHER XIX D	7,324
	EMPLOYEE PHYSICAL EXAMS XIX D	0
	INSURANCE - EXECUTIVE LIFE VI 21/XIX D	0
	PENSION/PROFIT SHARING PLANS XIX D	26,635
	CHICAGO HEAD TAX XIX D	8,028
23	<b>INSERVICE TRAINING &amp; EDUCATION</b>	656,448
	EDUCATION & SEMINARS	10,639
24	<b>TRAVEL &amp; SEMINARS</b>	
	EDUCATION & SEMINARS XIX G	0
	TRAVEL XIX G	7,654
		0
		0
25	<b>ADMIN. STAFF TRANSPORTATION</b>	11,780
	TRANSPORTATION - STAFF	12,249
26	<b>INSURANCE - PROP. LIAB &amp; MALPRACTICE</b>	
	GENERAL INSURANCE	105,960
27	<b>OTHER</b>	
	BAD DEBTS VI 24	365,583
		0
		365,583

GRAND TOTAL COLUMN 3 OTHER

2,563,000

LAKEVIEW NURSING & REHAB CTRE  
 EMPLOYEE MEAL RECLASSIFICATION  
 12/31/2001

TOTAL FOOD PURCHASE	230,918
LESS SALES TAX	0
	-----
NET FOOD	230,918
TOTAL PATIENT CENSUS	60,055
TIME 3 MEALS PER DAY	3
	-----
TOTAL PATIENT MEALS	180165
ADD # EMPLOYEE MEALS/DAY	25
TIME # DAYS	365
	-----
TOTAL EMPLOYEE MEALS	9125

PATIENT MEALS	180165
ADD EMPLOYEE MEALS	9125
	-----
TOTAL MEALS/YEAR	189290
NET FOOD	230918
DIVIDE TOTAL MEALS/YEAR	189290
COST PER MEAL	1.22
TIME EMPLOYEE MEALS	9125
	-----
EMPLOYEE MEAL RECLASSIFICATION	11133
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