



Facility Name & ID Number LAKE FRONT HEALTHCARE CENTER

# 0029942 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

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	99	Skilled (SNF)	99	36,135	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	99	TOTALS	99	36,135	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	584	22	1,086	1,692	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD	18,874	720	868	20,462	11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	19,458	742	1,954	22,154	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 61.31%

D. How many bed-hold days during this year were paid by the Department? NONE (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)  
NONE

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

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?  
YES  NO

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

I. On what date did you start providing long term care at this location?  
Date started 8/16/85

J. Was the facility purchased or leased after January 1, 1978?  
YES  Date 8/16/85 NO

K. Was the facility certified for Medicare during the reporting year?  
YES  NO  If YES, enter number of beds certified 12 and days of care provided 1,086

Medicare Intermediary ADMINISTAR FEDERAL

IV. ACCOUNTING BASIS

ACCRAUAL  MODIFIED CASH\*  CASH\*

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

Tax Year: 12/31/2005 Fiscal Year: 12/31/2005

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

Facility Name & ID Number **LAKE FRONT HEALTHCARE CENTER** # **0029942** Report Period Beginning: **01/01/2005** Ending: **12/31/2005**

**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	125,633	28,750	5,385	159,768		159,768		159,768		1
2	Food Purchase		114,893		114,893	(19,695)	95,198	(797)	94,401		2
3	Housekeeping	123,280	1,703		124,983		124,983		124,983		3
4	Laundry		9,631	2,848	12,479		12,479		12,479		4
5	Heat and Other Utilities			71,820	71,820		71,820		71,820		5
6	Maintenance	19,158	3,464	24,336	46,958		46,958		46,958		6
7	Other (specify):*			9,240	9,240		9,240		9,240		7
8	<b>TOTAL General Services</b>	<b>268,071</b>	<b>158,441</b>	<b>113,629</b>	<b>540,141</b>	<b>(19,695)</b>	<b>520,446</b>	<b>(797)</b>	<b>519,649</b>		<b>8</b>
	<b>B. Health Care and Programs</b>										
9	Medical Director										9
10	Nursing and Medical Records	750,380	59,589	10,319	820,288		820,288		820,288		10
10a	Therapy			260	260		260		260		10a
11	Activities	84,975	4,780	858	90,613		90,613		90,613		11
12	Social Services			355	355		355		355		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	<b>835,355</b>	<b>64,369</b>	<b>11,792</b>	<b>911,516</b>		<b>911,516</b>		<b>911,516</b>		<b>16</b>
	<b>C. General Administration</b>										
17	Administrative	147,841			147,841		147,841		147,841		17
18	Directors Fees										18
19	Professional Services			48,426	48,426		48,426		48,426		19
20	Dues, Fees, Subscriptions & Promotions			35,678	35,678		35,678	(17,367)	18,311		20
21	Clerical & General Office Expenses	62,791	6,256	14,060	83,107		83,107	(3,838)	79,269		21
22	Employee Benefits & Payroll Taxes			178,038	178,038	19,695	197,733		197,733		22
23	Inservice Training & Education										23
24	Travel and Seminar			705	705		705		705		24
25	Other Admin. Staff Transportation			2,423	2,423		2,423	(2,423)			25
26	Insurance-Prop.Liab.Malpractice			103,346	103,346		103,346		103,346		26
27	Other (specify):*										27
28	<b>TOTAL General Administration</b>	<b>210,632</b>	<b>6,256</b>	<b>382,676</b>	<b>599,564</b>	<b>19,695</b>	<b>619,259</b>	<b>(23,628)</b>	<b>595,631</b>		<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	<b>1,314,058</b>	<b>229,066</b>	<b>508,097</b>	<b>2,051,221</b>		<b>2,051,221</b>	<b>(24,425)</b>	<b>2,026,796</b>		<b>29</b>

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

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

V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE	SCHED REF	TOTAL
<b>1</b>	<b>DIETARY</b>	
	DIETITIAN CONSULTANT XVIII B 35-2	5,136
	REPAIRS & MAINTENANCE	249
		0
		5,385
<b>3</b>	<b>HOUSEKEEPING</b>	
		0
		0
		0
<b>4</b>	<b>LAUNDRY</b>	
	EQUIPMENT REPAIRS & MAINTENANCE	2,848
		0
		2,848
<b>5</b>	<b>HEAT &amp; OTHER UTILITIES</b>	
	GAS HEAT	33,319
	ELECTRICITY	30,101
	WATER	8,400
	CABLE TV - LOBBY	0
		0
		71,820
<b>6</b>	<b>MAINTENANCE</b>	
	GROUNDS MAINTENANCE	5
	PAINTING & DECORATING	0
	BUILDING REPAIRS	885
	MAINTENANCE TRAVEL	0
	EQUIPMENT MAINTENANCE & REPAIR	18,133
	ELEVATOR MAINTENANCE & REPAIR	5,313
	OUTSIDE LABOR	0
	EXTERMINATING SERVICE	0
	FIRE SERVICE	0
		0
		0
		24,336
<b>7</b>	<b>OTHER</b>	
	SCAVENGER	7,116
	SECURITY SERVICE	2,124
		9,240
<b>9</b>	<b>MEDICAL DIRECTOR</b>	
	MEDICAL DIRECTOR FEES XVIII B 36-2	0
		0

LINE	SCHED REF	TOTAL
<b>10</b>	<b>NURSING</b>	
	CONTRACT NURSING XVIII C 53-2	
	LABORATORY & XRAY EXPENSE	2,506
	PURCHASED SERVICES	0
	PSYCHO-SOCIAL CONSULTANT XVIII B __-2	0
	RESTORATIVE NURSING CONSULTANT XVIII B 38-2	0
	MEDICAL RECORDS CONSULTANT XVIII B 37-2	2,160
	PHARMACY CONSULTANT XVIII B 39-2	0
	UTILIZATION REVIEW FEES XVIII B __-2	0
	PHYSICIANS XVIII B __-2	0
	PSYCHIATRIC XVIII B __-2	1,000
	RN CONSULTANT XVIII B 38-2	0
	<b>DENTAL SERVICES</b>	3,060
	<b>DENTAL CONSULTANT</b>	1,593
		10,319
<b>10a</b>	<b>THERAPY</b>	
	PHYSICAL THERAPY SERVICES	
	SPEECH THERAPY SERVICES	0
	OCCUPATIONAL THERAPY SERVICES	0
	REHABILITATION CONSULTANT XVIII B __-2	260
	PHYSICAL THERAPY CONSULTANT XVIII B 40-2	0
	OCCUPATIONAL THERAPY CONSULTA XVIII B 41-2	0
	RESPIRATORY THERAPY CONSULTAN XVIII B 42-2	0
	<b>SPEECH THERAPY CONSULTANT XVIII B 43-2</b>	0
		260
<b>11</b>	<b>ACTIVITIES</b>	
	CABLE TV - PATIENT ROOMS	0
	ACTIVITY REHAB CONSULTANT XVIII B 44-2	858
		0
		858
<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	355
		0
		355
<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	0
17	<b>ADMINISTRATIVE</b>	
	MANAGEMENT FEES XIX B	0
18	<b>DIRECTORS FEES</b>	0
19	<b>PROFESSIONAL SERVICES</b>	
	DATA PROCESSING XIX C	16,288
	ADMINISTRATIVE CONSULTANTS XIX C	0
	PROFESSIONAL FEES XIX C	32,138
		0
		48,426
20	<b>FEES,SUBSCRIPTIONS,PROMOTIONS</b>	
	ENTERTAINMENT & MARKETING VI 19 XIX F	0
	ADV & PROMO-NON PATIENT RELATED VI 25 XIX F	10,063
	EMPLOYEE WANT ADS XIX F	7,415
	CONTRIBUTIONS VI 20 XIX F	5,000
	DUES & SUBSCRIPTIONS XIX F	8,518
	LICENSES & PERMITS XIX F	2,378
	PUBLIC RELATIONS-PATIENT RELATED XIX F	0
	ADVERTISING-YELLOW PAGES VI 28 XIX F	1,904
	TRUST FEES / FRANCHISE TAX / ETC VI 17 XIX F	400
	CONTRIBUTIONS - POLITICAL VI 20 XIX F	0
	HEALTH CARE WORKER BACKGROUND CHEC XIX F	0
		35,678
21	<b>CLERICAL &amp; GENERAL OFFICE EXPENSES</b>	
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)	3,838
	EQUIPMENT REPAIR & MAINTENANCE	802
	OUTSIDE CLERICAL SERVICES	0
	PENALTIES / OVERDRAFT CHARGES VI 18	0
	HOME OFFICE EXPENSE	0
	THEFT & DAMAGE LOSS	0
	TELEPHONE	9,420
	MESSENGER SERVICE	0
		0
		14,060

LINE	SCHED REF	TOTAL
22	<b>EMPLOYEE BENEFITS &amp; PAYROLL TAXES</b>	
	FICA TAXES XIX D	99,526
	UNEMPLOYMENT COMPENSATION XIX D	13,448
	WORKERS COMPENSATION INSURANCE XIX D	26,729
	HOSPITALIZATION INSURANCE XIX D	27,436
	EMPLOYEE BENEFITS - OTHER XIX D	2,126
	EMPLOYEE PHYSICAL EXAMS XIX D	0
	INSURANCE - EXECUTIVE LIFE VI 21/XIX D	0
	PENSION/PROFIT SHARING PLANS XIX D	5,857
	CHICAGO HEAD TAX XIX D	2,916
		178,038
23	<b>INSERVICE TRAINING &amp; EDUCATION</b>	
	EDUCATION & SEMINARS	0
		0
24	<b>TRAVEL &amp; SEMINARS</b>	
	EDUCATION & SEMINARS XIX G	705
	TRAVEL XIX G	0
		0
		0
		705
25	<b>ADMIN. STAFF TRANSPORTATION</b>	
	TRANSPORTATION - STAFF	2,423
		2,423
26	<b>INSURANCE - PROP. LIAB &amp; MALPRACTICE</b>	
	GENERAL INSURANCE	103,346
		103,346
27	<b>OTHER</b>	
	BAD DEBTS VI 24	0
		0

GRAND TOTAL COLUMN 3 OTHER

508,097

LAKE FRONT HEALTHCARE CENTER  
 EMPLOYEE MEAL RECLASSIFICATION (PAGE 3 SCHEDULE V COLUMN 5 LINES 2 AND 22)  
 12/31/2005

TOTAL FOOD PURCHASE	114,893	PATIENT MEALS	66462
LESS SALES TAX	(797)	ADD EMPLOYEE MEALS	13870
	-----		-----
NET FOOD	114,096	TOTAL MEALS/YEAR	80332
TOTAL PATIENT CENSUS	22,154	NET FOOD	114096
TIME 3 MEALS PER DAY	3	DIVIDE TOTAL MEALS/YEAR	80332
	-----		
TOTAL PATIENT MEALS	66462	COST PER MEAL	1.42
		TIME EMPLOYEE MEALS	13870
ADD # EMPLOYEE MEALS/DAY	38		-----
TIME # DAYS	365	EMPLOYEE MEAL RECLASSIFICATION	19695
	-----		=====
TOTAL EMPLOYEE MEALS	13870		

Facility Name &amp; ID Number LAKE FRONT HEALTHCARE CENTER

#0029942

Report Period Beginning:

01/01/2005

Ending:

12/31/2005

## 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			74,533	74,533		74,533	8,124	82,657			30
31	Amortization of Pre-Op. & Org.			6,914	6,914		6,914		6,914			31
32	Interest			189,150	189,150		189,150		189,150			32
33	Real Estate Taxes			73,748	73,748		73,748		73,748			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			1,138	1,138		1,138		1,138			35
36	Other (specify):* <b>amort software</b>			2,232	2,232		2,232		2,232			36
37	<b>TOTAL Ownership</b>			347,715	347,715		347,715	8,124	355,839			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		22,143	37,693	59,836		59,836		59,836			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			54,698	54,698		54,698		54,698			42
43	Other (specify):*											43
44	<b>TOTAL Special Cost Centers</b>		22,143	92,391	114,534		114,534		114,534			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	1,314,058	251,209	948,203	2,513,470		2,513,470	(16,301)	2,497,169			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 LAKE FRONT HEALTHCARE CENTER

# 0029942

Report Period Beginning:

01/01/2005

Ending:

12/31/2005

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	8,124	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	(797)	2		13
14	Non-Care Related Interest		32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)	(2,423)	25		16
17	Non-Care Related Fees	(400)	20		17
18	Fines and Penalties		21		18
19	Entertainment		20		19
20	Contributions	(5,000)	20		20
21	Owner or Key-Man Insurance		22		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt		27		24
25	Fund Raising, Advertising and Promotional	(10,063)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(1,904)	20		28
29	Other-Attach Schedule	(3,838)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (16,301)		\$	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)			34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ (16,301)		37

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

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

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

ID# 0029942

Report Period Beginning: 01/01/2005

Ending: 12/31/2005

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	DEFERRED MAINTENANCE	\$ 0	6	1
2	BANK CHARGES	(3,838)	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	<b>Total</b>	(3,838)		49

## STATE OF ILLINOIS

Summary A

Facility Name &amp; ID Number LAKE FRONT HEALTHCARE CENTER

# 0029942

Report Period Beginning:

01/01/2005

Ending:

12/31/2005

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

	Operating Expenses	PAGES	PAGE	SUMMARY										
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
		(to Sch V, col.7)												
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(797)	0	0	0	0	0	0	0	0	0	0	(797)	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	<b>TOTAL General Services</b>	<b>(797)</b>	<b>0</b>	<b>(797)</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	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	<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	(17,367)	0	0	0	0	0	0	0	0	0	0	(17,367)	20
21	Clerical & General Office Expenses	(3,838)	0	0	0	0	0	0	0	0	0	0	(3,838)	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	(2,423)	0	0	0	0	0	0	0	0	0	0	(2,423)	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	<b>TOTAL General Administration</b>	<b>(23,628)</b>	<b>0</b>	<b>(23,628)</b>	<b>28</b>									
29	<b>TOTAL Operating Expense</b> (sum of lines 8,16 & 28)	<b>(24,425)</b>	<b>0</b>	<b>(24,425)</b>	<b>29</b>									

## STATE OF ILLINOIS

Summary B

Facility Name &amp; ID Number LAKE FRONT HEALTHCARE CENTER

# 0029942

Report Period Beginning:

01/01/2005 Ending:

12/31/2005

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

	Capital Expense	PAGES	PAGE	SUMMARY										
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
30	Depreciation	8,124	0	0	0	0	0	0	0	0	0	0	8,124	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	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>8,124</b>	<b>0</b>	<b>8,124</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 (sum of lines 29, 37 &amp; 44)</b>	<b>(16,301)</b>	<b>0</b>	<b>(16,301)</b>	<b>45</b>									

Facility Name & ID Number

LAKE FRONT HEALTHCARE CENTER

# 0029942

Report Period Beginning:

01/01/2005

Ending:

12/31/2005

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
MALKA MERMELSTEIN	50	COMMUNIT NURSING & REHAB, LLC	NAPERVILLE			
HERMAN MERMELSTEIN	50					

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		\$	N/A		\$	\$	1
2	V							2
3	V							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		\$			\$	\$ *	14

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

Facility Name & ID Number LAKE FRONT HEALTHCARE CENTER # 0029942 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

## 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	MALKA MERMELSTEIN	ADMINISTRATOR	ADM	0.50				SALARY	\$ 103,633	17-1	1
2											2
3	HERMAN MERMELSTEIN		PURCH ACCT	0.50				SALARY	10,400	17-1	3
4											4
5	BLUMA JEREMIAS	ASST. ADM.	MEDICARE					SALARY	14,693	17-1	5
6	(DAUGHTER)		BILLING								6
7											7
8	MARK WELDLER	ADM. CONS.	ADM. CONS.		SEE ATTACHED			SALARY	19,115	17-1	8
9	(SON-IN-LAW)										9
10											10
11											11
12											12
13								TOTAL	\$ 147,841		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 **LAKE FRONT HEALTHCARE CENTER**

# **0029942**

Report Period Beginning: **01/01/2005**

Ending: **2/31/2005**

**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 \_\_\_\_\_

Street Address \_\_\_\_\_

City / State / Zip Code \_\_\_\_\_

Phone Number ( ) \_\_\_\_\_

Fax Number ( ) \_\_\_\_\_

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					\$	\$		\$	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	<b>TOTALS</b>				\$	\$		\$	25

Facility Name & ID Number LAKE FRONT HEALTHCARE CENTER

# 0029942

Report Period Beginning:

01/01/2005

Ending:

12/31/2005

**IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE**

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

1	Name of Lender	2		3	4	5	6		7	8	9	10						
		Related**					Purpose of Loan	Monthly Payment Required					Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO											Original	Balance			
<b>A. Directly Facility Related</b>																		
<b>Long-Term</b>																		
1	ORIX R/E CAP. MRKT LLC		X	MORTGAGE LOAN	\$23,560.00	8/96	\$ 2,600,000	\$ 1,934,460	8/16/16	9.1000	\$ 180,343	1						
2												2						
3												3						
4												4						
5												5						
<b>Working Capital</b>																		
6	AMERICAN NAT'L BANK		X	LINE OF CREDIT	INT	REVOLV		30,000	REVOLV	PRIME +	6,234	6						
7				INSURANCE							2,573	7						
8												8						
9	TOTAL Facility Related				\$23,560.00		\$ 2,600,000	\$ 1,964,460			\$ 189,150	9						
<b>B. Non-Facility Related*</b>																		
10	IRS, IDR, ETC		X	LATE FEES								10						
11												11						
12												12						
13												13						
14	TOTAL Non-Facility Related						\$	\$			\$	14						
15	TOTALS (line 9+line14)						\$ 2,600,000	\$ 1,964,460			\$ 189,150	15						

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

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

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

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

**B. Real Estate Taxes**

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

1. Real Estate Tax accrual used on 2004 report.	\$	<b>169,658</b>	<b>1</b>
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>121,703</b>	<b>2</b>
3. Under or (over) accrual (line 2 minus line 1).	\$	<b>(47,955)</b>	<b>3</b>
4. Real Estate Tax accrual used for 2005 report. (Detail and explain your calculation of this accrual on the lines below.)	\$	<b>121,703</b>	<b>4</b>
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>	\$		<b>5</b>
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 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>	\$		<b>6</b>
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	\$	<b>73,748</b>	<b>7</b>

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	<b>2000</b>	<b>113,510</b>	<b>8</b>
	<b>2001</b>	<b>116,462</b>	<b>9</b>
	<b>2002</b>	<b>117,768</b>	<b>10</b>
	<b>2003</b>	<b>169,659</b>	<b>11</b>
	<b>2004</b>	<b>121,703</b>	<b>12</b>

<b>FOR OHF USE ONLY</b>			
<b>13</b>	FROM R. E. TAX STATEMENT FOR 2004	\$	<b>13</b>
<b>14</b>	PLUS APPEAL COST FROM LINE 5	\$	<b>14</b>
<b>15</b>	LESS REFUND FROM LINE 6	\$	<b>15</b>
<b>16</b>	AMOUNT TO USE FOR RATE CALCULATION	\$	<b>16</b>

**THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED**

**ON ~ 101% OF THE PRIOR YEAR REAL ESTATE TAX BILL**

**THE PAYMENT ON LINE 2 APPLIES TO THE 2004 TAX BILL.**

**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.**



Facility Name & ID Number LAKE FRONT HEALTHCARE CENTER

# 0029942

Report Period Beginning:

01/01/2005 Ending:

12/31/2005

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 23,691 B. General Construction Type: Exterior BRICK Frame \_\_\_\_\_ Number of Stories \_\_\_\_\_

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

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

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

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

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

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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:

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1			1993	\$ 392,000	1
2					2
3	TOTALS			\$ 392,000	3

Facility Name &amp; ID Number LAKE FRONT HEALTHCARE CENTER

# 0029942

Report Period Beginning:

01/01/2005 Ending: 12/31/2005

**XI. OWNERSHIP COSTS (continued)****B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	99		1993		\$ 2,230,000	\$ 57,179	39	\$ 57,179	\$	\$ 693,304	4
5											5
6											6
7											7
8											8
	<b>Improvement Type**</b>										
9		TILING		1989	6,000	190			(190)	6,000	9
10		IMPROVEMENTS		1992	12,768	405	10		(405)	12,768	10
11		REMODEL LOUNGE		1993	1,685	43	39	43		525	11
12		BUILDING IMPROVEMENTS		1994	14,175	363	39	363		4,160	12
13		INSTALL DRYWALL, SPRINKLER SYSTEM		1995	10,987	282	39	282		2,750	13
14		INSTALL COLE BASE		1995	6,455	166	39	166		1,722	14
15		INSTALL CONCRETE ON FRONT		1995	1,500	38	39	38		392	15
16		NEW SLIDING WINDOW		1995	750	19	39	19		196	16
17		SEWAGE PUMP		1995	1,325	33	39	33		331	17
18		INSTALL NEW LIGHTS & ELECTRICAL		1996	1,850	47	39	47		441	18
19		ROOF FLASHING		1996	600	16	39	16		150	19
20		CONCRETE WORK		1996	3,850	99	39	99		928	20
21		WATER COOLER & PLUMBING		1996	3,404	87	39	87		830	21
22		TWO CONDENSOR COILS		1997	13,330	342	39	342		2,921	22
23		ALARM SYSTEM & ACCESS DOORS		1998	63,882	1,637	39	1,637		11,922	23
24		DRYWALL & CONDUITS		1998	12,435	319	39	319		2,277	24
25		FIRE DAMPERS & EXHAUST SYSTEM		1998	21,993	564	39	564		4,018	25
26		DRY CHEMICAL SAFETY SYSTEM		1999	1,922	49	39	49		321	26
27		HYDRAULIC PUMPS FOR ELEVATOR		1999	6,542	168	39	168		1,099	27
28		PLUMBING		1999	6,500	167	39	167		1,092	28
29		PLUMBING - AUDIT ADJUSTMENT		1999	(1,500)						29
30		NATURAL GAS GENERATOR & ELECTRICAL HOOK UP		1999	11,721	301	39	301		1,969	30
31		FIRE PROOF DOOR		1999	344	9	39	9		59	31
32		NEW FLOORS		1999	16,484	423	39	423		2,767	32
33		CEMENT WORK (STEPS & RAMP)		1999	4,400	113	39	113		739	33
34		NEW ROOF		1999	28,700	734	39	734		4,803	34
35		ELEVATOR REHAB		2002	10,350	376	27.5	376		1,332	35
36		BATTERY BACKUP EXIT SIGNS		2002	2,217	81	27.5	81		286	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

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37 FIRE ALARM SYSTEM UPDATE	2002	\$ 13,650	\$ 496	27.5	\$ 496	\$	\$ 1,757	37
38 DOORS	2002	3,600	131	27.5	131		464	38
39 SECURITY SYSTEM	2003	4,880	177	27.5	177		361	39
40 SPRINKLER HEADS	2004	5,213	190	27.5	190		261	40
41 WALLCOVERINGS	2005	18,729	3,746	5	3,746		3,746	41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67								67
68								68
69								69
70 TOTAL (lines 4 thru 69)		\$ 2,540,741	\$ 68,990		\$ 68,395	\$ (595)	\$ 766,691	70

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

**XI. OWNERSHIP COSTS (continued)**

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 181,280	\$ 1,993	\$ 7,208	\$ 5,215	10 YRS	\$ 157,588	71
72	Current Year Purchases							72
73	Fully Depreciated Assets	128,082					128,082	73
74								74
75	<b>TOTALS</b>	\$ 309,362	\$ 1,993	\$ 7,208	\$ 5,215		\$ 285,670	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	ADMINISTRATIVE	2001 TOYOTA AVALON	2001	\$ 35,262	\$ 3,550	\$ 7,054	\$ 3,504	5 YRS	\$ 35,262	76
77	ADMINISTRATIVE	BUICK	1996	30,301				5 YRS	30,301	77
78										78
79										79
80	<b>TOTALS</b>			\$ 65,563	\$ 3,550	\$ 7,054	\$ 3,504		\$ 65,563	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)	\$ 3,307,666	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 74,533	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 82,657	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 8,124	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,117,924	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	<b>TOTALS</b>	\$	\$	\$	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: \_\_\_\_\_

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

If NO, see instructions.  YES  NO

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

8. List separately any amortization of lease expense included on page 4, line 34. \_\_\_\_\_

This amount was calculated by dividing the total amount to be amortized \_\_\_\_\_  
by the length of the lease \_\_\_\_\_.

9. Option to Buy:  YES  NO Terms: \_\_\_\_\_\*

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

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

16. Rental Amount for movable equipment: \$ 1,138 Description: SEE SCHEDULE ATTACHED

(Attach a schedule detailing the breakdown of movable equipment)

**C. Vehicle Rental (See instructions.)**

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$ _____	\$ _____	17
18					18
19					19
20					20
21	TOTAL		\$ _____	\$ _____	21

10. Effective dates of current rental agreement:

Beginning \_\_\_\_\_

Ending \_\_\_\_\_

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

Fiscal Year Ending Annual Rent

12. \_\_\_\_\_/2006 \$ \_\_\_\_\_

13. \_\_\_\_\_/2007 \$ \_\_\_\_\_

14. \_\_\_\_\_/2008 \$ \_\_\_\_\_

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

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

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

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

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. <u>CLASSROOM PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
<p><b>THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES</b></p>		

**B. EXPENSES**

**ALLOCATION OF COSTS (d)**

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

**C. CONTRACTUAL INCOME**

In the box below record the amount of income your facility received training CNAs from other facilities.

\$

**D. NUMBER OF CNAs TRAINED**

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
<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 CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

- (e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
- (f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	\$		\$				1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-8	hrs			37,693			37,693	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-8	# of prescripts				22,143		22,143	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	<b>TOTAL</b>			\$		\$ 37,693	\$ 22,143		\$ 59,836	14

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

Facility Name & ID Number LAKE FRONT HEALTHCARE CENTER

# 0029942

Report Period Beginning: 01/01/2005

Ending:

12/31/2005

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2005

(last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 56,328	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance )	370,861		3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	33,208		7
8	Accounts Receivable (owners or related parties)	1,170		8
9	Other(specify): <u>Real Estate Escrow</u>	73,724		9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 535,291	\$	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	392,000		13
14	Buildings, at Historical Cost	2,230,000		14
15	Leasehold Improvements, at Historical Cost	312,241		15
16	Equipment, at Historical Cost	374,925		16
17	Accumulated Depreciation (book methods)	(1,117,963)		17
18	Deferred Charges	73,750		18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <u>Computer Software</u>	17,812		23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 2,282,765	\$	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 2,818,056	\$	25

		1	2	
		Operating	After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 263,396	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	30,000		29
30	Accrued Salaries Payable	49,158		30
31	Accrued Taxes Payable (excluding real estate taxes)	1,203		31
32	Accrued Real Estate Taxes(Sch.IX-B)	121,703		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>	\$ 465,460	\$	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable			39
40	Mortgage Payable	1,934,460		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>	\$ 1,934,460	\$	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 2,399,920	\$	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 418,136	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 2,818,056	\$	48

\*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>398,758</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>	<b>ROUNDING ADJUSTMENT</b>	<b>3</b>	<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>398,761</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>19,375</b>	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	( )	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ <b>19,375</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>418,136</b>	<b>24</b> *

\* 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	\$ 2,530,943	1
2	Discounts and Allowances for all Levels	( )	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 2,530,943	3
	<b>B. Ancillary Revenue</b>		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	8,111	6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 8,111	8
	<b>C. Other Operating Revenue</b>		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$	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>	\$	26
	<b>E. Other Revenue (specify):****</b>		
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<b>PRIOR YEAR EXPENSE</b>	(6,209)	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ (6,209)	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 2,532,845	30

2

	Expenses	Amount	
	<b>A. Operating Expenses</b>		
31	General Services	540,141	31
32	Health Care	911,516	32
33	General Administration	599,564	33
	<b>B. Capital Expense</b>		
34	Ownership	347,715	34
	<b>C. Ancillary Expense</b>		
35	Special Cost Centers	59,836	35
36	Provider Participation Fee	54,698	36
	<b>D. Other Expenses (specify):</b>		
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 2,513,470	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	19,375	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 19,375	43

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

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

TAX RETURN PREPARED ON CASH BASIS

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

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

Facility Name & ID Number LAKE FRONT HEALTHCARE CENTER

# 0029942

Report Period Beginning: 01/01/2005

Ending: 12/31/2005

**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	1,840	2,174	\$ 68,741	\$ 31.62	1
2	Assistant Director of Nursing					2
3	Registered Nurses	5,203	5,786	111,487	19.27	3
4	Licensed Practical Nurses	9,701	10,610	184,335	17.37	4
5	CNAs & Orderlies	37,925	41,945	385,817	9.20	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	6,427	7,050	84,975	12.05	10
11	Social Service Workers					11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	13,488	14,634	125,633	8.59	15
16	Dishwashers					16
17	Maintenance Workers	1,991	2,184	19,158	8.77	17
18	Housekeepers	13,761	14,918	123,280	8.26	18
19	Laundry					19
20	Administrator	4,170	4,453	114,033	25.61	20
21	Assistant Administrator	2,796	2,796	33,808	12.09	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	4,165	4,706	62,791	13.34	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)	101,467	111,256	\$ 1,314,058 *	\$ 11.81	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	\$ 5,136	1-3	35
36	Medical Director	0	9-3	36
37	Medical Records Consultant	monthly fees 2,160	10-3	37
38	Nurse Consultant	0	10-3	38
39	Pharmacist Consultant	0	10-3	39
40	Physical Therapy Consultant	0	10a-3	40
41	Occupational Therapy Consultant	0	10a-3	41
42	Respiratory Therapy Consultant	0	10a-3	42
43	Speech Therapy Consultant	0	10a-3	43
44	Activity Consultant	monthly fees 858	11-3	44
45	Social Service Consultant	monthly fees 355	12-3	45
46	Other(specify) <u>DENTAL</u>	monthly fees 1,593	10-3	46
47	<u>PSYCHIATRIC CONSULTANT</u>	monthly fees 1,000	10-3	47
48	<u>REHAB CONSULTANT</u>	monthly fees 260	10a-3	48
49	TOTAL (lines 35 - 48)	\$ 11,362		49

**C. CONTRACT NURSES**

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	\$ 0	10-3	50
51	Licensed Practical Nurses	0	10-3	51
52	Certified Nurse Assistants/Aides	0	10-3	52
53	TOTAL (lines 50 - 52)	\$		53



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

(See instructions.)

	1 Improvement Type	2 Month & Year Improvement Was Made	3 Total Cost	4 Useful Life	5-13 Amount of Expense Amortized Per Year								
					5 FY2002	6 FY2003	7 FY2004	8 FY2005	9 FY2006	10 FY2007	11 FY2008	12 FY2009	13 FY2010
					1	<b>PAINT/DECORATING</b>	<b>2000</b>	<b>\$ 2,320</b>	<b>3 YRS</b>	<b>\$ 774</b>	<b>\$ 385</b>		
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	<b>TOTALS</b>		<b>\$ 2,320</b>		<b>\$ 774</b>	<b>\$ 385</b>							

Facility Name &amp; ID Number LAKE FRONT HEALTHCARE CENTER

# 0029942

Report Period Beginning: 01/01/2005

Ending: 12/31/2005

**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 \$8213
- (3) Did the nursing home make political contributions or payments to a political action organization? NO If YES, have these costs been properly adjusted out of the cost report? \_\_\_\_\_
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity? \_\_\_\_\_
- (5) Have you properly capitalized all major repairs and equipment purchases? YES  
What was the average life used for new equipment added during this period? 10 YR
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 788 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? \_\_\_\_\_  
If YES, give effective date of lease. NO
- (9) Are you presently operating under a sublease agreement? \_\_\_\_\_ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES \_\_\_\_\_ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.  
\_\_\_\_\_
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 54,698  
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? NO If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? YES
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? NO For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 19,695 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