

		FOR OHF USE					

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**2005  
STATE OF ILLINOIS  
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES  
FINANCIAL AND STATISTICAL REPORT FOR  
LONG-TERM CARE FACILITIES  
(FISCAL YEAR 2005)**

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>0038943</u></p> <p><b>Facility Name:</b> <u>SOUTHVIEW MANOR</u></p> <p><b>Address:</b> <u>3311 SOUTH MICHIGAN AVENUE</u> <u>CHICAGO</u> <u>60616</u>  <small>Number City Zip Code</small></p> <p><b>County:</b> <u>COOK</u></p> <p><b>Telephone Number:</b> <u>( 847 ) 674-5795</u> <b>Fax #</b> <u>( 847 ) 674-5794</u></p> <p><b>IDPA ID Number:</b> <u>36-3924792</u></p> <p><b>Date of Initial License for Current Owners:</b> <u>12/16/93</u></p> <p><b>Type of Ownership:</b></p> <table border="0"> <tr> <td><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input checked="" type="checkbox"/> PROPRIETARY</td> <td><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td><b>IRS Exemption Code</b> _____</td> <td><input type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input checked="" type="checkbox"/> "Sub-S" Corp.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Limited Liability Co.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other _____</td> <td></td> </tr> </table> <p><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>01/01/2005</u> to <u>12/31/2005</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="1"> <tr> <td rowspan="2" style="width: 15%;"><b>Officer or Administrator of Provider</b></td> <td>(Signed) _____</td> </tr> <tr> <td>(Type or Print Name) <u>MORRIS ESFORMES</u> (Date) _____</td> </tr> <tr> <td></td> <td>(Title) <u>OFFICER</u></td> </tr> <tr> <td rowspan="4" style="width: 15%;"><b>Paid Preparer</b></td> <td>(Signed) <u>(SEE ATTACHED ACCOUNTANTS' REPORT)</u> (Date) _____</td> </tr> <tr> <td>(Print Name and Title) <u>BOB KAGDA</u> <u>PARTNER</u></td> </tr> <tr> <td>(Firm Name &amp; Address) <u>KRUPNICK, BOKOR, KAGDA &amp; BROOKS, LTD</u> <u>3750 W DEVON, LINCOLNWOOD, IL 60712-1124</u></td> </tr> <tr> <td>(Telephone) <u>( 847 ) 675-3585</u> <b>Fax #</b> <u>( 847 ) 675-5777</u></td> </tr> </table> <p align="right"><b>MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630</b></p>	<b>Officer or Administrator of Provider</b>	(Signed) _____	(Type or Print Name) <u>MORRIS ESFORMES</u> (Date) _____		(Title) <u>OFFICER</u>	<b>Paid Preparer</b>	(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, LINCOLNWOOD, IL 60712-1124</u>	(Telephone) <u>( 847 ) 675-3585</u> <b>Fax #</b> <u>( 847 ) 675-5777</u>
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Facility Name & ID Number SOUTHVIEW MANOR

# 0038943 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	74	Skilled (SNF)	74	27,010	1
2		Skilled Pediatric (SNF/PED)			2
3	126	Intermediate (ICF)	126	45,990	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	200	TOTALS	200	73,000	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	5,775		2,580	8,355	8
9	SNF/PED					9
10	ICF	63,386		599	63,985	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	69,161		3,179	72,340	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 99.10%

D. How many bed-hold days during this year were paid by the Department? 0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)

NONE

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

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

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

I. On what date did you start providing long term care at this location?  
Date started 12/16/93

J. Was the facility purchased or leased after January 1, 1978?  
YES  Date 12/16/93 NO

K. Was the facility certified for Medicare during the reporting year?  
YES  NO  If YES, enter number of beds certified 42 and days of care provided 2,580

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 &amp; ID Number

SOUTHVIEW MANOR

# 0038943

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	196,221	26,470	7,790	230,481		230,481		230,481		1
2	Food Purchase		239,636		239,636		239,636	(1,667)	237,969		2
3	Housekeeping	213,882	27,091		240,973		240,973		240,973		3
4	Laundry	67,421	12,079	3,673	83,173		83,173	1,571	84,744		4
5	Heat and Other Utilities			166,055	166,055		166,055		166,055		5
6	Maintenance	237,831	40,661	57,488	335,980		335,980	(8,903)	327,077		6
7	Other (specify):*			20,020	20,020		20,020	46	20,066		7
8	<b>TOTAL General Services</b>	715,355	345,937	255,026	1,316,318		1,316,318	(8,953)	1,307,365		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			2,400	2,400		2,400		2,400		9
10	Nursing and Medical Records	1,606,021	46,592	16,256	1,668,869		1,668,869		1,668,869		10
10a	Therapy	18,123		1,666	19,789		19,789		19,789		10a
11	Activities	98,597	9,324	354	108,275		108,275		108,275		11
12	Social Services	145,104		16,098	161,202		161,202		161,202		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	1,867,845	55,916	36,774	1,960,535		1,960,535		1,960,535		16
	<b>C. General Administration</b>										
17	Administrative	133,801		1,852,953	1,986,754		1,986,754	(166,759)	1,819,995		17
18	Directors Fees										18
19	Professional Services			39,122	39,122		39,122	12,553	51,675		19
20	Dues, Fees, Subscriptions & Promotions			17,235	17,235		17,235	(1,779)	15,456		20
21	Clerical & General Office Expenses	94,934	18,665	35,933	149,532		149,532	14,906	164,438		21
22	Employee Benefits & Payroll Taxes			540,025	540,025		540,025		540,025		22
23	Inservice Training & Education							30	30		23
24	Travel and Seminar			150	150		150		150		24
25	Other Admin. Staff Transportation			2,773	2,773		2,773	618	3,391		25
26	Insurance-Prop.Liab.Malpractice			89,796	89,796		89,796	2,701	92,497		26
27	Other (specify):*			419,333	419,333		419,333	(411,278)	8,055		27
28	<b>TOTAL General Administration</b>	228,735	18,665	2,997,320	3,244,720		3,244,720	(549,008)	2,695,712		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	2,811,935	420,518	3,289,120	6,521,573		6,521,573	(557,961)	5,963,612		29

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

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

V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE		SCHED REF	TOTAL
1	<b>DIETARY</b>		
	DIETITIAN CONSULTANT	XVIII B 35-2	7,790
	REPAIRS & MAINTENANCE		0
			0
			7,790
3	<b>HOUSEKEEPING</b>		
			0
			0
			0
4	<b>LAUNDRY</b>		
	EQUIPMENT REPAIRS & MAINTENANCE		3,673
			0
			3,673
5	<b>HEAT &amp; OTHER UTILITIES</b>		
	GAS HEAT		98,087
	ELECTRICITY		56,804
	WATER		11,164
	CABLE TV - LOBBY		0
			0
			166,055
6	<b>MAINTENANCE</b>		
	GROUNDS MAINTENANCE		1,580
	PAINTING & DECORATING		13,179
	BUILDING REPAIRS		0
	MAINTENANCE TRAVEL		0
	EQUIPMENT MAINTENANCE & REPAIR		17,155
	ELEVATOR MAINTENANCE & REPAIR		16,493
	OUTSIDE LABOR		0
	EXTERMINATING SERVICE		2,271
	FIRE SERVICE		6,810
			0
			0
			0
			57,488
7	<b>OTHER</b>		
	SCAVENGER		20,020
	SECURITY SERVICE		0
			20,020
9	<b>MEDICAL DIRECTOR</b>		
	MEDICAL DIRECTOR FEES	XVIII B 36-2	2,400
			2,400

LINE		SCHED REF	TOTAL
10	<b>NURSING</b>		
	CONTRACT NURSING	XVIII C 53-2	
	LABORATORY & XRAY EXPENSE		0
	PURCHASED SERVICES		0
	PSYCHO-SOCIAL CONSULTANT	XVIII B __-2	0
	RESTORATIVE NURSING CONSULTANT	XVIII B 38-2	0
	MEDICAL RECORDS CONSULTANT	XVIII B 37-2	0
	PHARMACY CONSULTANT	XVIII B 39-2	3,000
	UTILIZATION REVIEW FEES	XVIII B __-2	0
	PHYSICIANS	XVIII B __-2	4,000
	PSYCHIATRIC	XVIII B __-2	4,800
	RN CONSULTANT	XVIII B 38-2	0
	MDS CARE PLAN		856
	DENTAL		3,600
			16,256
10a	<b>THERAPY</b>		
	PHYSICAL THERAPY SERVICES		
	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	1,666
	RESPIRATORY THERAPY CONSULTAN	XVIII B 42-2	0
	SPEECH THERAPY CONSULTANT	XVIII B 43-2	0
			1,666
11	<b>ACTIVITIES</b>		
	CABLE TV - PATIENT ROOMS		0
	ACTIVITY REHAB CONSULTANT	XVIII B 44-2	354
			0
			354
12	<b>SOCIAL SERVICES</b>		
	SOCIAL REHABILITATION SERVICES		0
	SOCIAL REHABILITATION CONSULTAN	XVIII B 45-2	0
	SOCIAL WORKER	XVIII B 45-2	16,098
			0
			16,098
13	<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	1,852,953
18	<b>DIRECTORS FEES</b>	0
19	<b>PROFESSIONAL SERVICES</b>	
	DATA PROCESSING XIX C	14,799
	ADMINISTRATIVE CONSULTANTS XIX C	0
	PROFESSIONAL FEES XIX C	24,323
		0
		39,122
20	<b>FEES,SUBSCRIPTIONS,PROMOTIONS</b>	
	ENTERTAINMENT & MARKETING VI 19 XIX F	0
	ADV & PROMO-NON PATIENT RELATED VI 25 XIX F	1,272
	EMPLOYEE WANT ADS XIX F	528
	CONTRIBUTIONS VI 20 XIX F	0
	DUES & SUBSCRIPTIONS XIX F	11,608
	LICENSES & PERMITS XIX F	2,194
	PUBLIC RELATIONS-PATIENT RELATED XIX F	0
	ADVERTISING-YELLOW PAGES VI 28 XIX F	0
	TRUST FEES / FRANCHISE TAX / ETC VI 17 XIX F	104
	CONTRIBUTIONS - POLITICAL VI 20 XIX F	1,509
	HEALTH CARE WORKER BACKGROUND CHEC XIX F	20
		17,235
21	<b>CLERICAL &amp; GENERAL OFFICE EXPENSES</b>	
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)	1,071
	EQUIPMENT REPAIR & MAINTENANCE	272
	OUTSIDE CLERICAL SERVICES	9,000
	PENALTIES / OVERDRAFT CHARGES VI 18	190
	HOME OFFICE EXPENSE	0
	THEFT & DAMAGE LOSS	0
	TELEPHONE	25,400
	MESSENGER SERVICE	0
		0
		35,933

LINE	SCHED REF	TOTAL
22	<b>EMPLOYEE BENEFITS &amp; PAYROLL TAXES</b>	
	FICA TAXES XIX D	215,017
	UNEMPLOYMENT COMPENSATION XIX D	84,044
	WORKERS COMPENSATION INSURANCE XIX D	71,163
	HOSPITALIZATION INSURANCE XIX D	161,586
	EMPLOYEE BENEFITS - OTHER XIX D	3,062
	EMPLOYEE PHYSICAL EXAMS XIX D	0
	INSURANCE - EXECUTIVE LIFE VI 21/XIX D	0
	PENSION/PROFIT SHARING PLANS XIX D	0
	CHICAGO HEAD TAX XIX D	5,153
		540,025
23	<b>INSERVICE TRAINING &amp; EDUCATION</b>	
	EDUCATION & SEMINARS	0
		0
24	<b>TRAVEL &amp; SEMINARS</b>	
	EDUCATION & SEMINARS XIX G	150
	TRAVEL XIX G	0
		0
		0
		150
25	<b>ADMIN. STAFF TRANSPORTATION</b>	
	TRANSPORTATION - STAFF	2,773
		2,773
26	<b>INSURANCE - PROP. LIAB &amp; MALPRACTICE</b>	
	GENERAL INSURANCE	89,796
		89,796
27	<b>OTHER</b>	
	BAD DEBTS VI 24	419,333
		419,333

GRAND TOTAL COLUMN 3 OTHER

3,289,120

SOUTHVIEW MANOR  
 EMPLOYEE MEAL RECLASSIFICATION (PAGE 3 SCHEDULE V COLUMN 5 LINES 2 AND 22)  
 12/31/2005

TOTAL FOOD PURCHASE	239,636	PATIENT MEALS	217020
LESS SALES TAX	(1,667)	ADD EMPLOYEE MEALS	0
	-----		-----
NET FOOD	237,969	TOTAL MEALS/YEAR	217020
TOTAL PATIENT CENSUS	72,340	NET FOOD	237969
TIME 3 MEALS PER DAY	3	DIVIDE TOTAL MEALS/YEAR	217020
	-----		
TOTAL PATIENT MEALS	217020	COST PER MEAL	1.1
		TIME EMPLOYEE MEALS	0
ADD # EMPLOYEE MEALS/DAY	0		-----
TIME # DAYS	365	EMPLOYEE MEAL RECLASSIFICATION	0
	-----		=====
TOTAL EMPLOYEE MEALS	0		

Facility Name &amp; ID Number

SOUTHVIEW MANOR

#0038943

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			20,225	20,225		20,225	109,783	130,008			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			81,141	81,141		81,141	480,131	561,272			32
33	Real Estate Taxes			180,611	180,611		180,611		180,611			33
34	Rent-Facility & Grounds			780,000	780,000		780,000	(780,000)				34
35	Rent-Equipment & Vehicles			44,396	44,396		44,396	5,573	49,969			35
36	Other (specify):* software, goodwill			243,324	243,324		243,324	(240,000)	3,324			36
37	<b>TOTAL Ownership</b>			1,349,697	1,349,697		1,349,697	(424,513)	925,184			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		65,698	89,680	155,378		155,378		155,378			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			109,500	109,500		109,500		109,500			42
43	Other (specify):*											43
44	<b>TOTAL Special Cost Centers</b>		65,698	199,180	264,878		264,878		264,878			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	2,811,935	486,216	4,837,997	8,136,148		8,136,148	(982,474)	7,153,674			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 **SOUTHVIEW MANOR**

# **0038943**

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	
	<b>NON-ALLOWABLE EXPENSES</b>	<b>Amount</b>	<b>Refer- ence</b>	<b>OHF USE ONLY</b>	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	5,405	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	(1,667)	2		13
14	Non-Care Related Interest	(19,180)	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees	(104)	20		17
18	Fines and Penalties	(190)	21		18
19	Entertainment		20		19
20	Contributions	(1,509)	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	(419,333)	27		24
25	Fund Raising, Advertising and Promotional	(1,272)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising		20		28
29	Other-Attach Schedule	(262,554)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	<b>\$ (700,404)</b>		<b>\$</b>	<b>30</b>

<b>OHF USE ONLY</b>					
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	
		<b>Amount</b>	<b>Reference</b>	
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)	(282,070)		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	<b>\$ (282,070)</b>		<b>36</b>
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	<b>\$ (982,474)</b>		<b>37</b>

**\*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
		<b>Yes</b>	<b>No</b>	<b>Amount</b>	<b>Reference</b>
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>			<b>\$</b>	<b>47</b>

## SOUTHVIEW MANOR

ID# 0038943

Report Period Beginning: 01/01/2005

Ending: 12/31/2005

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	DEFERRED MAINTENANCE	\$ (10,983)	6	1
2	MARKETING SALARIES	(10,500)	21	2
3	BANK CHARGE	(1,071)	21	3
4	AMORTIZATION GOODWILL	(240,000)	36	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>	(262,554)		49

## STATE OF ILLINOIS

Summary A

Facility Name & ID Number SOUTHVIEW MANOR# 0038943

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	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	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	(1,667)	0	0	0	0	0	0	0	0	0	0	(1,667)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	1,571	0	0	0	0	0	0	0	0	1,571	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	(10,983)	0	2,080	0	0	0	0	0	0	0	0	(8,903)	6
7	Other (specify):*	0	0	46	0	0	0	0	0	0	0	0	46	7
8	<b>TOTAL General Services</b>	<b>(12,650)</b>	<b>0</b>	<b>3,697</b>	<b>0</b>	<b>(8,953)</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	(175,159)	8,400	0	0	0	0	0	0	0	0	(166,759)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	539	12,014	0	0	0	0	0	0	0	0	12,553	19
20	Fees, Subscriptions & Promotions	(2,885)	0	1,106	0	0	0	0	0	0	0	0	(1,779)	20
21	Clerical & General Office Expenses	(11,761)	7,847	18,820	0	0	0	0	0	0	0	0	14,906	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	30	0	0	0	0	0	0	0	0	30	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	89	529	0	0	0	0	0	0	0	0	618	25
26	Insurance-Prop.Liab.Malpractice	0	222	2,479	0	0	0	0	0	0	0	0	2,701	26
27	Other (specify):*	(419,333)	2,406	5,649	0	0	0	0	0	0	0	0	(411,278)	27
28	<b>TOTAL General Administration</b>	<b>(433,979)</b>	<b>(164,056)</b>	<b>49,027</b>	<b>0</b>	<b>(549,008)</b>	<b>28</b>							
29	<b>TOTAL Operating Expense</b> <b>(sum of lines 8,16 &amp; 28)</b>	<b>(446,629)</b>	<b>(164,056)</b>	<b>52,724</b>	<b>0</b>	<b>(557,961)</b>	<b>29</b>							

## STATE OF ILLINOIS

Summary B

Facility Name & ID Number SOUTHVIEW MANOR# 0038943

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	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	5,405	0	290	0	104,088	0	0	0	0	0	0	109,783	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(19,180)	0	0	0	499,311	0	0	0	0	0	0	480,131	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	(780,000)	0	0	0	0	0	0	(780,000)	34
35	Rent-Equipment & Vehicles	0	451	5,122	0	0	0	0	0	0	0	0	5,573	35
36	Other (specify):*	(240,000)	0	0	0	0	0	0	0	0	0	0	(240,000)	36
37	<b>TOTAL Ownership</b>	<b>(253,775)</b>	<b>451</b>	<b>5,412</b>	<b>0</b>	<b>(176,601)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(424,513)</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>(700,404)</b>	<b>(163,605)</b>	<b>58,136</b>	<b>0</b>	<b>(176,601)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(982,474)</b>	<b>45</b>

Facility Name & ID Number

SOUTHVIEW MANOR

# 0038943

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
				EKS MGMT	LINCOLNWOOD	BOOKKEEPING
				EMI ENTERPRISES	LINCOLNWOOD	MGMT.CONSU
				IME REALTY	LINCOLNWOOD	HOME OFFICE
SEE ATTACHED SCHEDULE		SEE ATTACHED SCHEDULE		E & N LIMITED		
				PARTNERSHIP	LINCOLNWOOD	REAL ESTATE

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

YES  NO

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
1	V	17	MANAGEMENT FEES	\$ 190,000	EMI ENTERPRISES, INC		\$	\$ (190,000)	1
2	V								2
3	V								3
4	V	17	OFFICERS SALARY			14,841		14,841	4
5	V	19	ACCOUNTING FEES			539		539	5
6	V	21	OFFICE EXPENSE			7,847		7,847	6
7	V	25	TRANSPORTATION			89		89	7
8	V	26	INSURANCE			222		222	8
9	V	27	EMPLOYEE BENEFITS			2,406		2,406	9
10	V								10
11	V	35	AUTO LEASE			451		451	11
12	V								12
13	V								13
14	Total		\$ 190,000			\$ 26,395	\$ *	(163,605)	14

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	21 BOOKKEEPING FEES	\$ 9,000	EKS MANAGEMENT		\$	\$ (9,000)
16	V						
17	V	4 HOUSEKEEPING SALARIES				1,560	1,560
18	V	4 CLEANING SUPPLIES				11	11
19	V	6 PAINTING SALARIES				2,080	2,080
20	V	7 SCAVENGER				46	46
21	V	17 CFO SALARY				8,400	8,400
22	V	19 PROFESSIONAL FEES				12,014	12,014
23	V	20 WANT ADS/BACKGR CKS				1,106	1,106
24	V	21 OFFICE EXPENSE				27,820	27,820
25	V	23 SEMINARS				30	30
26	V	24 IN-STATE LODGING/MEALS					
27	V	25 TRANSPORTATION				529	529
28	V	26 INSURANCE				2,479	2,479
29	V	27 EMPLOYEE BENEFITS				5,649	5,649
30	V	30 DEPRECIATION				290	290
31	V	35 EQUIPMENT RENTAL				5,122	5,122
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 9,000			\$ 67,136	\$ * 58,136

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

**VII. RELATED PARTIES (continued)**

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	36 OFFICE RENT	\$	IME REALTY CORP		\$	\$	15
16	V							16
17	V	5 UTILITIES						17
18	V	6 REPAIRS & MAINTENANCE						18
19	V	7 ALARM SERVICE						19
20	V	19 PROFESSIONAL FEES						20
21	V	21 OFFICE EXPENSE						21
22	V	26 INSURANCE						22
23	V	30 DEPRECIATION						23
24	V	32 INTEREST						24
25	V	33 RE TAX						25
26	V	35 STORAGE FEES						26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$	0	\$ *

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	34 RENT	\$ 780,000	E&N LIMITED PARTNERSHIP		\$	(780,000)
16	V	30 SL - DEPRECIATION BUILDING				104,088	104,088
17	V	32 INTEREST ALBANY BANK				288,091	288,091
18	V	32 INTEREST - SHELDON NEIDICH				211,220	211,220
19	V						
20	V						
21	V						
22	V						
23	V						
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 780,000			\$ 603,399	\$ * (176,601)

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

Facility Name &amp; ID Number

SOUTHVIEW MANOR

#

0038943

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	MORRIS ESFORMES		ADMIN	32.34	SEE			MNMT FEE	\$ 14,841	17-7	1
2					ATTACHED						2
3	PHILIP ESFORMES		ADMIN	32.33	SCHEDULE			MNMT FEE	190,000	17-7	3
4											4
5	SHELDON NEIDICH		ADMIN	32.33				MNMT FEE	1,472,953	17-7	5
6											6
7	AVRUM WEINFELD		CFO					SALARY	8,400	17-7	7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 1,686,194		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 SOUTHVIEW MANOR

# 0038943

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

Name of Related Organization EMI ENTERPRISES  
 Street Address 6865 N. LINCOLN AVE.  
 City / State / Zip Code LINCOLNWOOD, IL 60712  
 Phone Number ( 847 ) 674-5795  
 Fax Number ( 847 ) 674-5794

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	17	OFFICERS SALARY	PATIENT DAYS	901,761	15	\$ 185,000	\$ 72,340	\$ 14,841	1
2	19	ACCOUNTING FEES	PATIENT DAYS	901,761	15	6,725	72,340	539	2
3	21	OFFICE EXPENSE	PATIENT DAYS	901,761	15	97,823	72,340	7,847	3
4	25	TRANSPORTATION	PATIENT DAYS	901,761	15	1,114	72,340	89	4
5	26	INSURANCE	PATIENT DAYS	901,761	15	2,768	72,340	222	5
6	27	EMPLOYEE BENEFITS	PATIENT DAYS	901,761	15	29,997	72,340	2,406	6
7	35	AUTO LEASE	PATIENT DAYS	901,761	15	5,617	72,340	451	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					\$ 329,044	\$ 264,576	\$ 26,395	25

Facility Name & ID Number **SOUTHVIEW MANOR**

# **0038943**

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

Name of Related Organization EKS MANAGEMENT  
 Street Address 6865 N. LINCOLN AVE.  
 City / State / Zip Code LINCOLNWOOD, IL 60712  
 Phone Number ( 847 ) 674-5795  
 Fax Number ( 847 ) 674-5794

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

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	4	HOUSEKEEPING SALARIES	PATIENT DAYS	901,761	15	\$ 19,441	\$ 19,441	72,340	\$ 1,560	1
2	4	CLEANING SUPPLIES	PATIENT DAYS	901,761	15	140	72,340	72,340	11	2
3	6	PAINTING SALARIES	PATIENT DAYS	901,761	15	25,925	25,925	72,340	2,080	3
4	7	SCAVENGER	PATIENT DAYS	901,761	15	573	72,340	72,340	46	4
5	17	CFO SALARY	PATIENT DAYS	901,761	15	104,714	104,714	72,340	8,400	5
6	19	PROFESSIONAL FEES	PATIENT DAYS	901,761	15	149,759	72,340	72,340	12,014	6
7	20	WANT ADS/BACKGR CKS	PATIENT DAYS	901,761	15	13,787	72,340	72,340	1,106	7
8	21	OFFICE EXPENSE	PATIENT DAYS	901,761	15	346,792	248,929	72,340	27,820	8
9	23	SEMINARS	PATIENT DAYS	901,761	15	380	72,340	72,340	30	9
10	24	IN-STATE LODGING/MEALS	PATIENT DAYS	901,761	15		72,340	72,340		10
11	25	TRANSPORTATION	PATIENT DAYS	901,761	15	6,593	72,340	72,340	529	11
12	26	INSURANCE	PATIENT DAYS	901,761	15	30,900	72,340	72,340	2,479	12
13	27	EMPLOYEE BENEFITS	PATIENT DAYS	901,761	15	70,423	72,340	72,340	5,649	13
14	30	DEPRECIATION	PATIENT DAYS	901,761	15	3,617	72,340	72,340	290	14
15	35	EQUIPMENT RENTAL	PATIENT DAYS	901,761	15	63,848	72,340	72,340	5,122	15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 836,892	\$ 399,009		\$ 67,136	25

Facility Name & ID Number SOUTHVIEW MANOR

# 0038943

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

IME REALTY CORP.

Street Address

6865 N. LINCOLN AVE.

City / State / Zip Code

LINCOLNWOOD, IL 70712

Phone Number

( 847) 674-5795

Fax Number

( 847) 674-5794

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	5	UTILITIES	INCOME	346,361	15	\$	\$		1
2	6	REPAIRS & MAINTENANCE	INCOME	346,361	15				2
3	7	ALARM SERVICE	INCOME	346,361	15				3
4	19	PROFESSIONAL FEES	INCOME	346,361	15				4
5	21	OFFICE EXPENSE	INCOME	346,361	15				5
6	26	INSURANCE	INCOME	346,361	15				6
7	30	DEPRECIATION	INCOME	346,361	15				7
8	32	INTEREST	INCOME	346,361	15				8
9	33	RE TAX	INCOME	346,361	15				9
10	35	STORAGE FEES	INCOME	346,361	15				10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$	\$		25

Facility Name & ID Number **SOUTHVIEW MANOR**

# **0038943**

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 E&N LIMITED PARTNERSHIP  
 Street Address 6865 N. LINCOLN AVE  
 City / State / Zip Code LINCOLNWOOD,IL. 60712  
 Phone Number ( 847 )674-5795  
 Fax Number ( 847 )674-5794

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	DIRECT	1	1	\$ 104,088	\$ 1	\$ 104,088	1
2	32	INTEREST	DIRECT	1	1	288,091	1	288,091	2
3	32	INTEREST	DIRECT	1	1	211,220	1	211,220	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					\$ 603,399	\$	\$ 603,399	25

Facility Name & ID Number

SOUTHVIEW MANOR

# 0038943

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	ALBANY BANK		X	MORTGAGE	\$37,369.00		\$ 5,800,000	\$ 5,714,396	2/01/08	6.0000	\$ 288,091	1						
2	SHELDON NEIDICH	X		MORTGAGE	\$22,872.00		3,550,000	3,492,220	2/01/08	6.0000	211,220	2						
3												3						
4												4						
5												5						
<b>Working Capital</b>																		
6	ALBANY BANK		X	WORKING V\CAPTITAL	INTEREST			852,000	REVOLV	PRIME +	81,141	6						
7												7						
8	RELATED PARTIES	X										8						
9	TOTAL Facility Related				\$60,241.00		\$ 9,350,000	\$ 10,058,616			\$ 580,452	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)						\$ 9,350,000	\$ 10,058,616			\$ 580,452	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>237,359</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>208,985</b>	<b>2</b>
3. Under or (over) accrual (line 2 minus line 1).		\$	<b>(28,374)</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>208,985</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>180,611</b>	<b>7</b>

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	<b>2000</b>	<b>257,634</b>	<b>8</b>
	<b>2001</b>	<b>266,344</b>	<b>9</b>
	<b>2002</b>	<b>269,331</b>	<b>10</b>
	<b>2003</b>	<b>237,359</b>	<b>11</b>
	<b>2004</b>	<b>208,985</b>	<b>12</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.**

<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>

**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:** 2004 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 2004 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2004.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2004 real estate tax bill to the Department of Public Aid, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

**Please send these items in with your completed 2005 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed.** If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

**2004 LONG TERM CARE REAL ESTATE TAX STATEMENT**

FACILITY NAME SOUTHVIEW MANOR COUNTY COOK

FACILITY IDPH LICENSE NUMBER 0038943

CONTACT PERSON REGARDING THIS REPORT BOB KAGDA

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

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

Enter the tax index number and real estate tax assessed for 2004 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 2004.

(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>17-34-116-003-0000</u>	<u>NURSING HOME</u>	\$ <u>72,353.70</u>	\$ <u>72,353.70</u>
2. <u>17-34-116-004-0000</u>	<u>NURSING HOME</u>	\$ <u>41,127.09</u>	\$ <u>41,127.09</u>
3. <u>17-34-116-005-0000</u>	<u>NURSING HOME</u>	\$ <u>31,226.11</u>	\$ <u>31,226.11</u>
4. <u>17-34-116-006-0000</u>	<u>NURSING HOME</u>	\$ <u>31,226.11</u>	\$ <u>31,226.11</u>
5. <u>17-34-116-007-0000</u>	<u>NURSING HOME</u>	\$ <u>31,226.11</u>	\$ <u>31,226.11</u>
6. <u>17-34-116-008-0000</u>	<u>NURSING HOME</u>	\$ <u>1,825.72</u>	\$ <u>1,825.72</u>
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ <u>208,984.84</u>	\$ <u>208,984.84</u>

**B. Real Estate Tax Cost Allocations**

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

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

**C. Tax Bills**

Attach a copy of the original 2004 tax bills which were listed in Section A to this statement. Be sure to use the 2004 tax bill which is normally paid during 2005.

Facility Name & ID Number SOUTHVIEW MANOR

# 0038943

Report Period Beginning:

01/01/2005 Ending:

12/31/2005

**X. BUILDING AND GENERAL INFORMATION:**

A. Square Feet: 91,960 B. General Construction Type: Exterior 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).

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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

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

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

**XI. OWNERSHIP COSTS:**

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	<u>NURSING HOME</u>			\$ <u>145,695</u>	<u>1</u>
2					<u>2</u>
3	<b>TOTALS</b>			\$ <b>145,695</b>	<b>3</b>

Facility Name & ID Number **SOUTHVIEW MANOR**# **0038943**

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	200		1993		\$ 4,059,425	\$ 104,088	39	\$ 104,088	\$	\$ 1,253,400	4
5											5
6											6
7	RELATED PARTY				46,019						7
8	IME										8
	<b>Improvement Type**</b>										
9	LEASEHOLD IMPROVEMENT		1994		4,931	126	39	126		1,454	9
10	HEAT EXCHANGER		1995		4,895	126	39	126		1,370	10
11	TUB-PLUMBING		1995		11,279	289	39	289		3,143	11
12	WINDOWS		1995		613	16	39	16		169	12
13	BOILER		1995		5,239	134	39	134		1,390	13
14	DOOR REPLACEMENT		1996		4,397	113	39	113		1,087	14
15	DOOR RESTRICTORS ON ELEVATORS		1997		3,042	78	39	78		666	15
16	ALARM SYSTEM		1997		3,664	94	39	94		803	16
17	SAFETY GLASS		1997		2,099	54	39	54		461	17
18	HEATER EXHAUST STACK		1998		3,185	81	39	81		618	18
19	AIR DUCTS		1998		3,085	79	39	79		603	19
20	ACCESS PANELS		1998		2,466	63	39	63		465	20
21	HEAT EXCHANGER		1995		8,440	216	39	216		1,593	21
22	AIR DUCTS		1998		3,298	85	39	85		627	22
23	FIRE DAMPERS		1998		24,840	637	39	637		4,539	23
24	ACCESS PANELS		1998		2,724	70	39	70		499	24
25	FIRE PANELS		1998		1,264	33	39	33		235	25
26	BOILER		1999		4,830	124	39	124		811	26
27	FIRE DAMPERS		1999		8,280	212	39	212		1,387	27
28	ELEVATOR IMPROVEMENT		1999		5,000	128	39	128		837	28
29	FIRE DOORS		1999		5,535	142	39	142		929	29
30	SPRINKLER SYSTEM		1999		3,945	101	39	101		661	30
31	NEW ROOF		2000		7,000	255	27.5	255		1,413	31
32	ROOF		2003		15,390	559	27.5	559		1,421	32
33	DOOR		2003		2,300	84	27.5	84		213	33
34	WATER HEATER		2003		23,160	842	27.5	842		1,719	34
35	ELEVATOR IMPROVEMENT		2004		42,035	1,529	27.5	1,529		1,593	35
36	SMOKE DETECTIVE		2004		5,265	191	27.5	191		199	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.

**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	ROOF	2004	\$ 8,500	\$ 309	27.5	\$ 309	\$	\$ 605	37
38	TILING	2005	5,791	114	27.5	114		114	38
39	FIRE ALARM SYSTEM	2005	28,329	558	27.5	558		558	39
40	CARPETING	2005	1,643	329	5	164	(165)	164	40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 4,361,908	\$ 111,859		\$ 111,694	\$ (165)	\$ 1,285,746	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	\$ 187,669	\$ 9,653	\$ 17,324	\$ 7,671	10 YRS	\$ 126,978	71
72	Current Year Purchases	14,006	2,801	700	(2,101)	10 YRS	700	72
73	Fully Depreciated Assets	57,512				10 YRS	57,512	73
74	<b>RELATED PARTES</b>	500,000	290	290				74
75	<b>TOTALS</b>	\$ 759,187	\$ 12,744	\$ 18,314	\$ 5,570		\$ 185,190	75

D. Vehicle Depreciation (See instructions.)\*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	<b>TOTALS</b>			\$	\$	\$	\$		\$	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)	\$ 5,266,790	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 124,603	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 130,008	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 5,405	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,470,936	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:	<u>200</u>		\$ <u>780,000</u>			3
4	Additions						4
5							5
6							6
7	<b>TOTAL</b>	<b>200</b>		\$ <b>780,000</b>			<b>7</b>

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? \_\_\_\_\_

16. Rental Amount for movable equipment: \$ 22,986 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	ADMINISTRATION	2005 LEXUS RX330	\$ <u>689.00</u>	\$ <u>9,161</u>	17
18	FACILITY	2004 FORD E350	<u>662.50</u>	<u>8,095</u>	18
19	ADMINISTRATION	2003 JAGUAR S	<u>770.00</u>	<u>1,540</u>	19
20	PAINTERS	2003 CHEVY ASTRO VAN	<u>645.50</u>	<u>2,614</u>	20
21	<b>TOTAL</b>		\$ <b>#####</b>	\$ <b>21,410</b>	<b>21</b>

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	39-8	hrs	\$		\$ 80,758	\$		\$ 80,758	1
2	Licensed Speech and Language Development Therapist	39-8	hrs			302			302	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-8	hrs			8,620			8,620	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				63,662		63,662	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): lab	39-8					2,036		2,036	13
14	<b>TOTAL</b>			\$		\$ 89,680	\$ 65,698		\$ 155,378	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 &amp; ID Number SOUTHVIEW MANOR

# 0038943

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	\$ 22,280	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance (360,000) )	1,592,476		3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	106,511		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	<b>TOTAL Current Assets</b> (sum of lines 1 thru 9)	\$ 1,721,267	\$	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	254,821		15
16	Equipment, at Historical Cost	330,368		16
17	Accumulated Depreciation (book methods)	(336,977)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <u>NET GOODWILL</u>	699,600		23
24	<b>TOTAL Long-Term Assets</b> (sum of lines 11 thru 23)	\$ 947,812	\$	24
25	<b>TOTAL ASSETS</b> (sum of lines 10 and 24)	\$ 2,669,079	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 206,101	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	865,520		29
30	Accrued Salaries Payable	122,405		30
31	Accrued Taxes Payable (excluding real estate taxes)	34,615		31
32	Accrued Real Estate Taxes(Sch.IX-B)	208,985		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</b> (sum of lines 26 thru 37)	\$ 1,437,626	\$	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable	2,751,038		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</b> (sum of lines 39 thru 44)	\$ 2,751,038	\$	45
46	<b>TOTAL LIABILITIES</b> (sum of lines 38 and 45)	\$ 4,188,664	\$	46
47	<b>TOTAL EQUITY</b> (page 18, line 24)	\$ (1,519,585)	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY</b> (sum of lines 46 and 47)	\$ 2,669,079	\$	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1 Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>76,295</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>	<b>POST CLOSING ENTRIES</b>	<b>(985,445)</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>(909,150)</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>(71,534)</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>(538,901)</b>	<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>(610,435)</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>(1,519,585)</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	\$ 8,024,121	1
2	Discounts and Allowances for all Levels	( )	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 8,024,121	3
	<b>B. Ancillary Revenue</b>		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	21,313	6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 21,313	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***	19,180	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 19,180	26
	<b>E. Other Revenue (specify):****</b>		
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28			28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 8,064,614	30

2

	Expenses	Amount	
	<b>A. Operating Expenses</b>		
31	General Services	1,316,318	31
32	Health Care	1,960,535	32
33	General Administration	3,244,720	33
	<b>B. Capital Expense</b>		
34	Ownership	1,349,697	34
	<b>C. Ancillary Expense</b>		
35	Special Cost Centers	155,378	35
36	Provider Participation Fee	109,500	36
	<b>D. Other Expenses (specify):</b>		
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 8,136,148	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	(71,534)	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ (71,534)	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 **SOUTHVIEW MANOR**

# 0038943

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	3,376	3,505	\$ 105,340	\$ 30.05	1
2	Assistant Director of Nursing					2
3	Registered Nurses	10,337	11,304	271,419	24.01	3
4	Licensed Practical Nurses	27,884	32,285	643,823	19.94	4
5	CNAs & Orderlies	58,882	63,325	524,951	8.29	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,851	1,981	18,123	9.15	8
9	Activity Director					9
10	Activity Assistants	9,573	10,512	98,597	9.38	10
11	Social Service Workers	9,070	9,920	145,104	14.63	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	21,276	22,888	196,221	8.57	15
16	Dishwashers					16
17	Maintenance Workers	21,663	22,961	237,831	10.36	17
18	Housekeepers	23,165	25,312	213,882	8.45	18
19	Laundry	8,436	9,139	67,421	7.38	19
20	Administrator	3,294	3,463	78,428	22.65	20
21	Assistant Administrator	2,499	2,628	55,373	21.07	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	7,299	7,682	94,934	12.36	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,076	2,284	30,680	13.43	31
32	Other Health C: <u>QA, CARE PLAN</u>	1,604	1,604	29,808	18.58	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	212,285	230,793	\$ 2,811,935 *	\$ 12.18	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	monthly fee	\$ 7,790	1-3	35
36	Medical Director	monthly fee	2,400	9-3	36
37	Medical Records Consultant		0	10-3	37
38	Nurse Consultant		0	10-3	38
39	Pharmacist Consultant	monthly fee	3,000	10-3	39
40	Physical Therapy Consultant		0	10a-3	40
41	Occupational Therapy Consultant	monthly fee	1,666	10a-3	41
42	Respiratory Therapy Consultant		0	10a-3	42
43	Speech Therapy Consultant		0	10a-3	43
44	Activity Consultant	monthly fee	354	11-3	44
45	Social Service Consultant	monthly fee	16,098	12-3	45
46	Other(specify) <u>Psychiatric</u>	monthly fee	4,800	10-3	46
47	<u>MDS &amp; Physician</u>	monthly fee	4,856	10-3	47
48	<u>dental</u>	monthly fee	3,600	10-3	48
49	TOTAL (lines 35 - 48)		\$ 44,564		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	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009	FY2010
1	PAINT/DECORATING	2005	\$ 13,179	3 yrs	\$	\$	\$	\$ 2,196	\$ 4,393	\$ 4,393	\$ 2,197	\$	\$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$ 13,179		\$	\$	\$	\$ 2,196	\$ 4,393	\$ 4,393	\$ 2,197	\$	\$

Facility Name &amp; ID Number SOUTHVIEW MANOR

# 0038943

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 \$11,377
- (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. \$ 0 Line 10-2
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? NO  
If YES, give effective date of lease. \_\_\_\_\_
- (9) Are you presently operating under a sublease agreement? \_\_\_\_\_ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES \_\_\_\_\_ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.  
\_\_\_\_\_
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 109,500  
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? NO If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? YES
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? NO For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? \_\_\_\_\_ 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