

		FOR BHF USE					

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2006
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2006)

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>I. IDPH Facility ID Number: <u>0026484</u></p> <p>Facility Name: <u>LAKEVIEW NURSING & REHABILITATION CENTER</u></p> <p>Address: <u>735 WEST DIVERSEY</u> <u>CHICAGO</u> <u>60614</u> Number City Zip Code</p> <p>County: <u>COOK</u></p> <p>Telephone Number: <u>(847) 784-8204</u> Fax # <u>(847) 784-8248</u></p> <p>HFS ID Number: <u>36-3133316</u></p> <p>Date of Initial License for Current Owners: <u>8/14/1981</u></p> <p>Type of Ownership:</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>IRS Exemption Code _____</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>In the event there are further questions about this report, please contact: Name: <u>BOB KAGDA</u> Telephone Number: <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	IRS Exemption Code _____	<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>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/2006</u> to <u>12/31/2006</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="3" style="width: 15%;">Officer or Administrator of Provider</td> <td>(Signed) _____</td> </tr> <tr> <td>(Type or Print Name) <u>JOHN BERNARDI</u> (Date) _____</td> </tr> <tr> <td>(Title) <u>CFO</u></td> </tr> <tr> <td rowspan="5">Paid Preparer</td> <td>(Signed) <u>(SEE ATTACHED ACCOUNTANTS' REPORT)</u> (Date) _____</td> </tr> <tr> <td>(Print Name and Title) <u>BOB KAGDA</u> <u>VICE PRESIDENT</u></td> </tr> <tr> <td>(Firm Name & Address) <u>KRUPNICK, BOKOR, KAGDA & BROOKS, LTD</u> <u>3750 W DEVON, LINCOLNWOOD, IL 60712-1124</u></td> </tr> <tr> <td>(Telephone) <u>(847) 675-3585</u> Fax # <u>(847) 675-5777</u></td> </tr> <tr> <td>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</td> </tr> </table>	Officer or Administrator of Provider	(Signed) _____	(Type or Print Name) <u>JOHN BERNARDI</u> (Date) _____	(Title) <u>CFO</u>	Paid Preparer	(Signed) <u>(SEE ATTACHED ACCOUNTANTS' REPORT)</u> (Date) _____	(Print Name and Title) <u>BOB KAGDA</u> <u>VICE PRESIDENT</u>	(Firm Name & Address) <u>KRUPNICK, BOKOR, KAGDA & BROOKS, LTD</u> <u>3750 W DEVON, LINCOLNWOOD, IL 60712-1124</u>	(Telephone) <u>(847) 675-3585</u> Fax # <u>(847) 675-5777</u>	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
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Facility Name & ID Number LAKEVIEW NURSING & REHABILITATION CENTER

0026484 Report Period Beginning: 01/01/2006 Ending: 12/31/2006

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 06/28/06

	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	<u>180</u>	Skilled (SNF)	<u>178</u>	<u>65,312</u>	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	<u>180</u>	TOTALS	<u>178</u>	<u>65,312</u>	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	<u>574</u>	<u>15</u>	<u>13,163</u>	<u>13,752</u>	8
9	SNF/PED					9
10	ICF	<u>39,220</u>	<u>5,900</u>	<u>36</u>	<u>45,156</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>39,794</u>	<u>5,915</u>	<u>13,199</u>	<u>58,908</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 90.19%

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 08/15/81

J. Was the facility purchased or leased after January 1, 1978?
YES Date 08/14/81 NO

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 178 and days of care provided 11,201

Medicare Intermediary ADMINISTAR

IV. ACCOUNTING BASIS

ACCRAUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/2006 Fiscal Year: 12/31/2006

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

Facility Name & ID Number LAKEVIEW NURSING & REHABILITATION # 0026484 Report Period Beginning: 01/01/2006 Ending: 12/31/2006

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

	Operating Expenses	Costs Per General Ledger				Reclassification 5	Reclassified Total 6	Adjustments 7	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	389,396	44,851	23,012	457,259		457,259	0	457,259		1
2	Food Purchase		324,178		324,178	(18,944)	305,234	0	305,234		2
3	Housekeeping	329,263	43,273	0	372,536		372,536	0	372,536		3
4	Laundry	75,718	30,965	1,542	108,225	0	108,225	0	108,225		4
5	Heat and Other Utilities			172,912	172,912		172,912	0	172,912		5
6	Maintenance	106,744	61,930	22,025	190,699		190,699	(1,627)	189,072		6
7	Other (specify):*			18,458	18,458		18,458	0	18,458		7
8	TOTAL General Services	901,121	505,197	237,949	1,644,267	(18,944)	1,625,323	(1,627)	1,623,696		8
	B. Health Care and Programs										
9	Medical Director	0		57,000	57,000		57,000	0	57,000		9
10	Nursing and Medical Records	3,026,654	313,161	32,943	3,372,758		3,372,758	0	3,372,758		10
10a	Therapy	428,581	1,985	2,351	432,917		432,917	0	432,917		10a
11	Activities	132,655	2,131	23,027	157,813		157,813	0	157,813		11
12	Social Services	83,200		2,359	85,559		85,559	0	85,559		12
13	CNA Training		2,358	0	2,358		2,358	0	2,358		13
14	Program Transportation			3,036	3,036		3,036	0	3,036		14
15	Other (specify):*				0		0	0	0		15
16	TOTAL Health Care and Programs	3,671,090	319,635	120,716	4,111,441	0	4,111,441	0	4,111,441		16
	C. General Administration										
17	Administrative	341,480		0	341,480		341,480	0	341,480		17
18	Directors Fees			0	0		0	0	0		18
19	Professional Services			83,815	83,815		83,815	(3,121)	80,694		19
20	Dues, Fees, Subscriptions & Promotions			139,652	139,652		139,652	(50,653)	88,999		20
21	Clerical & General Office Expenses	459,270	68,258	119,669	647,197		647,197	(173,833)	473,364		21
22	Employee Benefits & Payroll Taxes			1,030,581	1,030,581	18,944	1,049,525	0	1,049,525		22
23	Inservice Training & Education			0	0		0	0	0		23
24	Travel and Seminar			9,198	9,198		9,198	(3,842)	5,356		24
25	Other Admin. Staff Transportation			19,008	19,008		19,008	(3,141)	15,867		25
26	Insurance-Prop.Liab.Malpractice			173,327	173,327		173,327	0	173,327		26
27	Other (specify):*			100,000	100,000		100,000	(100,000)	0		27
28	TOTAL General Administration	800,750	68,258	1,675,250	2,544,258	18,944	2,563,202	(334,590)	2,228,612		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	5,372,961	893,090	2,033,915	8,299,966	0	8,299,966	(336,217)	7,963,749		29

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

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

V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE	SCHED REF	TOTAL
1	DIETARY	
	DIETITIAN CONSULTANT XVIII B 35-2	21,207
	REPAIRS & MAINTENANCE	1,805
		0
		23,012
3	HOUSEKEEPING	
		0
		0
		0
4	LAUNDRY	
	EQUIPMENT REPAIRS & MAINTENANCE	1,542
		0
		1,542
5	HEAT & OTHER UTILITIES	
	GAS HEAT	81,043
	ELECTRICITY	71,244
	WATER	20,625
	CABLE TV - LOBBY	
		0
		172,912
6	MAINTENANCE	
	GROUNDS MAINTENANCE	1,955
	PAINTING & DECORATING	2,930
	BUILDING REPAIRS	0
	MAINTENANCE TRAVEL	0
	EQUIPMENT MAINTENANCE & REPAIR	4,254
	ELEVATOR MAINTENANCE & REPAIR	6,022
	OUTSIDE LABOR	0
	EXTERMINATING SERVICE	2,659
	FIRE SERVICE	4,205
		0
		0
		0
		0
		22,025
7	OTHER	
	SCAVENGER	16,058
	SECURITY SERVICE	2,400
		0
		0
		18,458
9	MEDICAL DIRECTOR	
	MEDICAL DIRECTOR FEES XVIII B 36-2	57,000
		57,000

LINE	SCHED REF	TOTAL
10	NURSING	
	CONTRACT NURSING XVIII C 53-2	27,261
	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	4,576
	PHARMACY CONSULTANT XVIII B 39-2	0
	UTILIZATION REVIEW FEES XVIII B ___-2	0
	PHYSICIANS XVIII B ___-2	0
	PSYCHIATRIC XVIII B ___-2	0
	RN CONSULTANT XVIII B 38-2	1,106
		0
		32,943
10a	THERAPY	
	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	2,351
	RESPIRATORY THERAPY CONSULTAN XVIII B 42-2	0
	SPEECH THERAPY CONSULTANT XVIII B 43-2	0
		2,351
11	ACTIVITIES	
	CABLE TV - PATIENT ROOMS	20,627
	ACTIVITY REHAB CONSULTANT XVIII B 44-2	2,400
		0
		23,027
12	SOCIAL SERVICES	
	SOCIAL REHABILITATION SERVICES	0
	SOCIAL REHABILITATION CONSULTAN XVIII B 45-2	0
	SOCIAL WORKER XVIII B 45-2	2,359
		0
		2,359
13	NURSE AIDE TRAINING	
	NURSE AIDE TRAINING COSTS XIII	0

V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE	SCHED REF	TOTAL
14	PROGRAM TRANSPORTATION	
	PATIENT TRANSPORTATION	3,036
17	ADMINISTRATIVE	
	MANAGEMENT FEES XIX B	0
18	DIRECTORS FEES	
	DIRECTORS FEES	0
19	PROFESSIONAL SERVICES	
	DATA PROCESSING XIX C	11,718
	ADMINISTRATIVE CONSULTANTS XIX C	0
	PROFESSIONAL FEES XIX C	72,097
		0
		83,815
20	FEES,SUBSCRIPTIONS,PROMOTIONS	
	ENTERTAINMENT & MARKETING VI 19 XIX F	33,240
	ADV & PROMO-NON PATIENT RELATED VI 25 XIX F	7,140
	EMPLOYEE WANT ADS XIX F	62,834
	CONTRIBUTIONS VI 20 XIX F	2,700
	DUES & SUBSCRIPTIONS XIX F	17,101
	LICENSES & PERMITS XIX F	3,414
	PUBLIC RELATIONS-PATIENT RELATED XIX F	0
	ADVERTISING-YELLOW PAGES VI 28 XIX F	3,432
	TRUST FEES / FRANCHISE TAX / ETC VI 17 XIX F	0
	CONTRIBUTIONS - POLITICAL VI 20 XIX F	4,141
	HEALTH CARE WORKER BACKGROUND CHEC XIX F	5,650
	PATIENT BACKGROUND CHECKS XIX F	0
		139,652
21	CLERICAL & GENERAL OFFICE EXPENSES	
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)	12,092
	EQUIPMENT REPAIR & MAINTENANCE	49,251
	OUTSIDE CLERICAL SERVICES	0
	PENALTIES / OVERDRAFT CHARGES VI 18	18,199
	HOME OFFICE EXPENSE	0
	THEFT & DAMAGE LOSS	0
	TELEPHONE	37,900
	MESSENGER SERVICE	2,227
		0
		119,669

LINE	SCHED REF	TOTAL
22	EMPLOYEE BENEFITS & PAYROLL TAXES	
	FICA TAXES XIX D	402,305
	UNEMPLOYMENT COMPENSATION XIX D	59,878
	WORKERS COMPENSATION INSURANC XIX D	123,921
	HOSPITALIZATION INSURANCE XIX D	380,710
	EMPLOYEE BENEFITS - OTHER XIX D	10,942
	EMPLOYEE PHYSICAL EXAMS XIX D	0
	INSURANCE - EXECUTIVE LIFE VI 21/XIX D	0
	PENSION/PROFIT SHARING PLANS XIX D	44,329
	CHICAGO HEAD TAX XIX D	8,496
		0
		1,030,581
23	INSERVICE TRAINING & EDUCATION	
	EDUCATION & SEMINARS	
		0
24	TRAVEL & SEMINARS	
	EDUCATION & SEMINARS XIX G	3,931
	TRAVEL XIX G	5,267
		9,198
25	ADMIN. STAFF TRANSPORTATION	
	TRANSPORTATION - STAFF	19,008
		19,008
26	INSURANCE - PROP. LIAB & MALPRACTICE	
	GENERAL INSURANCE	173,327
		173,327
27	OTHER	
	BAD DEBTS VI 24	100,000
		100,000

GRAND TOTAL COLUMN 3 OTHER

2,033,915

LAKEVIEW NURSING & REHABILITATION CENTER
 EMPLOYEE MEAL RECLASSIFICATION (PAGE 3 SCHEDULE V COLUMN 5 LINES 2 AND 22)
 12/31/2006

TOTAL FOOD PURCHASE	324,178	PATIENT MEALS	176724
LESS SALES TAX	0	ADD EMPLOYEE MEALS	10950
	-----		-----
NET FOOD	324,178	TOTAL MEALS/YEAR	187674
TOTAL PATIENT CENSUS	58,908	NET FOOD	324178
TIME 3 MEALS PER DAY	3	DIVIDE TOTAL MEALS/YEAR	187674

TOTAL PATIENT MEALS	176724	COST PER MEAL	1.73
		TIME EMPLOYEE MEALS	10950
ADD # EMPLOYEE MEALS/DAY	30		-----
TIME # DAYS	365	EMPLOYEE MEAL RECLASSIFICATION	18944
	-----		=====
TOTAL EMPLOYEE MEALS	10950		

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	
	D. Ownership											
30	Depreciation			179,340	179,340		179,340	130,386	309,726			30
31	Amortization of Pre-Op. & Org.			0	0		0	0	0			31
32	Interest			191,840	191,840		191,840	606,319	798,159			32
33	Real Estate Taxes				0		0	167,081	167,081			33
34	Rent-Facility & Grounds			942,365	942,365		942,365	(942,365)	0			34
35	Rent-Equipment & Vehicles			90,278	90,278		90,278	0	90,278			35
36	Other (specify):*				0		0	0	0			36
37	TOTAL Ownership			1,403,823	1,403,823	0	1,403,823	(38,579)	1,365,244			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation				0		0	0	0			38
39	Ancillary Service Centers		426,528	50,196	476,724		476,724	0	476,724			39
40	Barber and Beauty Shops				0		0	0	0			40
41	Coffee and Gift Shops				0		0	0	0			41
42	Provider Participation Fee			97,968	97,968		97,968	0	97,968			42
43	Other (specify):*				0		0	0	0			43
44	TOTAL Special Cost Centers	0	426,528	148,164	574,692	0	574,692	0	574,692			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	5,372,961	1,319,618	3,585,902	10,278,481	0	10,278,481	(374,796)	9,903,685			45

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

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(52,282)	30		9
10	Interest and Other Investment Income	(520)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax		2		13
14	Non-Care Related Interest	0	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees	0	20		17
18	Fines and Penalties	(18,199)	21		18
19	Entertainment	(33,240)	20		19
20	Contributions	(6,841)	20		20
21	Owner or Key-Man Insurance	0	22		21
22	Special Legal Fees & Legal Retainers	(3,121)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(100,000)	27		24
25	Fund Raising, Advertising and Promotional	(7,140)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(3,432)	20		28
29	Other-Attach Schedule	(164,244)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (389,019)		\$ 0	30

BHF USE ONLY					
48	49	50	51	52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	14,223		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 14,223		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (374,796)		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	TOTAL (C): (sum of lines 38-46)			\$	47

STATE OF ILLINOIS
 LAKEVIEW NURSING & REHABILITATION CENTER

ID# 0026484

Report Period Beginning: 01/01/2006

Ending: 12/31/2006

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	DEFERRED MAINTENANCE	\$ (1,627)	6	1
2	MARKETING SALARIES	(155,634)	21	2
3	OUT OF STATE TRAVEL	(3,842)	24	3
4	MARKETING - TRANSPORTATION	(3,141)	25	4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(164,244)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number LAKEVIEW NURSING & REHABILITATION CENTER

0026484

Report Period Beginning:

01/01/2006

Ending:

12/31/2006

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	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	(1,627)	0	0	0	0	0	0	0	0	0	0	(1,627)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(1,627)	0	(1,627)	8									
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(3,121)	0	0	0	0	0	0	0	0	0	0	(3,121)	19
20	Fees, Subscriptions & Promotions	(50,653)	0	0	0	0	0	0	0	0	0	0	(50,653)	20
21	Clerical & General Office Expenses	(173,833)	0	0	0	0	0	0	0	0	0	0	(173,833)	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	(3,842)	0	0	0	0	0	0	0	0	0	0	(3,842)	24
25	Other Admin. Staff Transportation	(3,141)	0	0	0	0	0	0	0	0	0	0	(3,141)	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	(100,000)	0	0	0	0	0	0	0	0	0	0	(100,000)	27
28	TOTAL General Administration	(334,590)	0	(334,590)	28									
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(336,217)	0	(336,217)	29									

STATE OF ILLINOIS

Summary B

Facility Name & ID Number LAKEVIEW NURSING & REHABILITATION CENTER # 0026484 Report Period Beginning: 01/01/2006 Ending: 12/31/2006

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(52,282)	182,668	0	0	0	0	0	0	0	0	0	130,386	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(520)	606,839	0	0	0	0	0	0	0	0	0	606,319	32
33	Real Estate Taxes	0	167,081	0	0	0	0	0	0	0	0	0	167,081	33
34	Rent-Facility & Grounds	0	(942,365)	0	0	0	0	0	0	0	0	0	(942,365)	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	TOTAL Ownership	(52,802)	14,223	0	(38,579)	37								
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(389,019)	14,223	0	(374,796)	45								

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
SAM BOREK	50			BOREK &		
HILLARD GARLOVSKY	50			GOLDHIRSCH	WILMETTE	LAW FIRM
				735 W. DIVERSEY		
				BUILDING, LLC	CHICAGO	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: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V	34 RENT	\$ 942,365	735 WEST DIVERSEY BUILDING, LLC	100.00%	\$	(942,365)	1
2	V	30 SL DEPRECIATION				182,668	182,668	2
3	V	32 INTEREST				557,568	557,568	3
4	V	33 REAL ESTATE TAX				167,081	167,081	4
5	V	32 MORTGAGE INSURANCE				49,271	49,271	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		\$ 942,365			\$ 956,588	\$ * 14,223	14

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

Facility Name & ID Number LAKEVIEW NURSING & REHABILITAT # 0026484 Report Period Beginning: 01/01/2006 Ending: 12/31/2006

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	SAM BOREK	PRESIDENT	ADMINISTRAT	50.00		30	60.00	SALARY	\$ 146,000	17-1	1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 146,000		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number LAKEVIEW NURSING & REHABILITATION CENTER # 0026484 Report Period Beginning: 01/01/2006 Ending: 2/31/2006

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	TOTALS				\$	\$		\$	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	Name of Lender	2		3	4	5	6		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			
A. Directly Facility Related																		
Long-Term																		
1	RELATED PARTY: 735 DIVERSEY BUILDING, LLC						\$	\$			\$	1						
2	CAMBRIDGE REALTY		X	MORTGAGE	\$77,801.29	05/04	10,055,500	9,697,547	05/39	5.6000	601,151	2						
3	LOAN COSTS		X	LOAN COSTS	W/O OVER LOAN		199,085	184,153			5,688	3						
4	BEACON FUNDING		X	EQUIPMENT LEASE							50,678	4						
5	MB FINANCIAL BANK		X	LOAN	DEMAND	12/22/04	600,000	216,659	02/08	PRIME +	24,861	5						
Working Capital																		
6	MB FINANCIAL BANK	X		WORKING CAPITAL	DEMAND		1,377,000	2,055,188		PRIME +	112,622	6						
7	GLENVIEW STATE BANK		X	AUTO				17,619			773	7						
8	MEPCO INSURANCE		X	INSURANCE FINANCE							2,906	8						
9	TOTAL Facility Related				\$77,801.29		\$ 12,231,585	\$ 12,171,166			\$ 798,679	9						
B. Non-Facility Related*																		
10	IRS, IDR, ETC		X	LATE FEES								10						
11												11						
12												12						
13												13						
14	TOTAL Non-Facility Related						\$ 0	\$ 0			\$ 0	14						
15	TOTALS (line 9+line14)						\$ 12,231,585	\$ 12,171,166			\$ 798,679	15						

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 49,271 Line # 32

* 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 2005 report.	\$	163,747	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	\$	165,414	2
3. Under or (over) accrual (line 2 minus line 1).	\$	1,667	3
4. Real Estate Tax accrual used for 2006 report. (Detail and explain your calculation of this accrual on the lines below.)	\$	165,414	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)	\$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)	\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	\$	167,081	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2001	183,591	8
	2002	177,670	9
	2003	162,353	10
	2004	163,747	11
	2005	165,414	12

FOR BHF USE ONLY			
13	FROM R. E. TAX STATEMENT FOR 2005	\$	13
14	PLUS APPEAL COST FROM LINE 5	\$	14
15	LESS REFUND FROM LINE 6	\$	15
16	AMOUNT TO USE FOR RATE CALCULATION	\$	16

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 2005 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.**

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 46,604 B. General Construction Type: Exterior BRICK Frame BRICK & STEEL Number of Stories 3 & BASEMENT

C. Does the Operating Entity? (a) Own the Facility (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.
 (Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? (a) Own the Equipment (b) Rent equipment from a Related Organization. (c) Rent equipment from Completely Unrelated Organization.
 (Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

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

N/A

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

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

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

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	<u>NURSING HOME</u>		<u>2001</u>	<u>\$ 558,037</u>	<u>1</u>
2					<u>2</u>
3	TOTALS			\$ 558,037	3

Facility Name & ID Number LAKEVIEW NURSING & REHABILITATION CENTER

0026484

Report Period Beginning:

01/01/2006 Ending: 12/31/2006

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

1	2	3	4	5	6	7	8	9		
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	180	2001		\$ 5,022,332	\$ 128,778	39	\$ 128,778	\$	\$ 745,994	4
5										5
6										6
7										7
8										8
	Improvement Type**									
9	LEASEHOLD IMPROVEMENTS		1982	2,850					2,850	9
10	LEASEHOLD IMPROVEMENTS		1983	2,500		15			2,500	10
11	LEASEHOLD IMPROVEMENTS		1985	2,312		10			2,312	11
12	LEASEHOLD IMPROVEMENTS		1985	3,200		20	80	80	3,200	12
13	LEASEHOLD IMPROVEMENTS		1987	29,042	922	20	1,452	530	27,378	13
14	LEASEHOLD IMPROVEMENTS		1987	8,647	275	31.5	275		5,221	14
15	LEASEHOLD IMPROVEMENTS		1988	13,520	429	31.5	429		8,071	15
16	LEASEHOLD IMPROVEMENTS		1989	17,460	554	5		(554)	17,460	16
17	LEASEHOLD IMPROVEMENTS		1989	6,534	207	15		(207)	6,534	17
18	LEASEHOLD IMPROVEMENTS		1990	20,612	654	31.5	654		11,118	18
19	LEASEHOLD IMPROVEMENTS		1991	40,916	1,299	31.5	1,299		20,134	19
20	LEASEHOLD IMPROVEMENTS		1992	40,819	1,296	31.5	1,296		18,860	20
21	LEASEHOLD IMPROVEMENTS		1993	10,482	333	31.5	333		4,607	21
22	LEASEHOLD IMPROVEMENTS		1993	16,965	435	39	435		5,738	22
23	LEASEHOLD IMPROVEMENTS		1994	9,602	246	39	246		3,127	23
24	ROOF REPAIR		1995	3,188	82	39	82		948	24
25	SHOWER RECONSTRUCTION		1995	7,775	200	39	200		2,202	25
26	SHOWER ROOMS RENOVATION		1996	35,634	914	39	914		9,681	26
27	OFFICE CONSTRUCTION		1996	4,647	119	39	119		1,243	27
28	ELECTRIC SLIDING DOOR		1996	1,380	35	39	35		356	28
29	BRICKWORK/TUCKPOINT		1997	1,680	43	39	43		417	29
30	PARKING LOT		1997	1,900	49	39	49		574	30
31	CLOSET WORK		1997	800	20	39	20		197	31
32	CONSULTING AND INSTALL FIREDOORS		1997	23,621	606	39	606		5,525	32
33	FIRE ALARM PANEL		1998	3,500	90	39	90		791	33
34	ROOF EXHAUST FANS, INSTALLATION FIRE DAMPTERS		1998	20,698	531	39	531		4,621	34
35	FRONT PORCH ENTRANCE, ONE MARQUEE CANOPY		1998	2,247	57	39	57		490	35
36	SMOKE DAMPERS		1998	1,669	43	39	43		360	36

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

See Page 12A, Line 70 for total

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

Facility Name & ID Number LAKEVIEW NURSING & REHABILITATION CENTER

0026484

Report Period Beginning:

01/01/2006 Ending: 12/31/2006

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	WALK IN FREEZER-NEW CONDENSING UNIT	1998	\$ 5,546	\$ 142	39	\$ 142		\$ 1,166	37
38	CEILING & LIGHT FIXTURES, ELECTRICAL	1998	30,226	775	39	775		6,234	38
39	CAFETERIAS - 1ST AND 3RD FLOOR	1999	3,000	77	39	77		606	39
40	LIGHTING, ELECTRICAL WORK, INSTALL CABLE	1999	27,482	705	39	705		5,529	40
41	DOORS REPAIR & PAINT-1ST,2ND AND 3RD FLOOR	1999	25,070	643	39	643		4,929	41
42	PLUMBING ROUGH	1999	10,300	264	39	264		2,035	42
43	PAINT WORK-1ST,END,3RD FLOOR, BASEMENT	1999	21,014	539	39	539		4,020	43
44	WALLCOVERING, CARPET TILES	1999	55,627	1,426	39	1,426		10,681	44
45	GENERATOR EXHAUST PIPE	1999	2,300	59	39	59		450	45
46	HANDRAILS-1ST,2ND,3RD FLOOR, BASEMENT	1999	24,340	624	39	624		4,730	46
47	ALARM SYSTEM	1999	107,758	2,763	39	2,763		21,478	47
48	DINING ROOM - 2ND AND 3RD FLOOR	1999	12,206	313	39	313		2,337	48
49	SHOWER AND FRONT STOOP REPAIR	1999	4,300	110	39	110		814	49
50	WINDOWS, CLOSETS, EXTERIOR	1999	4,415	113	39	113		752	50
51	INSTALLATION OF THE FIRE DAMPERS	1999	5,880	151	39	151		1,189	51
52	PLEATED SHADES	2000	949	0	20	47	47	329	52
53	CANVAS CANOPY	2000	3,996	102	39	102		695	53
54	INSTALLATION OF COOLING TOWER	2000	24,450	627	39	627		4,205	54
55	ALARM SYSTEM - ADDITIONAL PROTECTION	2000	1,970	51	39	51		342	55
56	DIALYSIS ROOM EXTRA CIRCUITS	2000	1,983	51	39	51		342	56
57	MICROLIGHT DETECTORS	2000	3,800	97	39	97		631	57
58	REPAIR DRYWALL	2000	3,744	96	39	96		601	58
59	ELECTRICAL PANEL FOR DIALYSIS CENTER	2000	2,380	61	39	61		379	59
60	INSTALLED 9 DOOR HOLDERS	2000	3,465	89	39	89		545	60
61	REMODELING NEW NORTHFIELD OFFICE	2001	3,440	88	39	88		525	61
62	TWO PASSENGER ELEVATOR	2001	84,711	2,172	39	2,172		11,675	62
63	TUCKPOINTING	2001	3,160	81	39	81		422	63
64	REPAVE DRIVEWAY & PARKING LOT	2001	7,000	179	39	179		956	64
65	ELECTRICAL WORK	2001	11,922	306	39	306		1,579	65
66	ROOF REPAIR	2001	7,945	204	39	204		1,077	66
67	PAINTING, WALLPAPERING, DRYWALL	2001	42,598	1,092	39	1,092		7,625	67
68	BACKUP GENERATOR	2002	6,375	163	39	163		809	68
69	ELECTRICAL WORK	2002	5,000	128	39	128		635	69
70	TOTAL (lines 4 thru 69)		\$ 5,914,884	\$ 152,508		\$ 152,404	\$ (104)	\$ 1,012,831	70

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

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 5,914,884	\$ 152,508		\$ 152,404	\$ (104)	\$ 1,012,831	1
2	ROOF & GUTTER REPAIR	2002	7,000	180	39	180		892	2
3	FLOORING & TILE IN CAFETERIA	2002	5,368	138	20	268	130	1,340	3
4	REPAIR DRIVEWAY & PARKING LOT	2002	3,300	85	15	220	135	1,100	4
5	CABINET INSTALLATION IN MAINTENANCE ROOM	2002	3,200	82	39	82		393	5
6	CARPETING INSTALLATION IN WAITING AREA	2002	3,561	91	20	178	87	890	6
7	REPLACE CABLE IN ELEVATOR	2002	5,800	149	39	149		701	7
8	BATHROOM SHOWER	2003	8,075	207	39	207		733	8
9	BOILER RE-TUBING	2003	21,850	560	39	560		1,890	9
10	CARPETING AND SHADES	2003	5,186	710	20	259	(451)	1,036	10
11	PLUMBING REVISIONS FOR DIALYSIS LOOP PIPING	2004	14,993	545	27.5	545		1,340	11
12	SPRINKLER SYSTEM & FIRE ALARM REPAIR	2005	6,556	238	27.5	238		387	12
13	ASPHALT PAVEMENT	2006	3,859	172	15	257	85	257	13
14	SLIDING DOORS & CIRCUIT TO A NEW DOOR OPENER	2006	5,890	98	27.5	98		98	14
15	BUILDING RENOVATION AND REMODELING	2006	685,986	11,433	27.5	11,433		11,433	15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 6,695,508	\$ 167,196		\$ 167,078	\$ (118)	\$ 1,035,321	34

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

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 653,214	\$ 69,980	\$ 63,928	\$ (6,052)	10 YRS	\$ 357,418	71
72	Current Year Purchases	322,709	64,542	16,135	(48,407)	10 YRS	16,135	72
73	Fully Depreciated Assets	589,804			0		589,804	73
74	RELATED PARTY		53,890	53,890	0			74
75	TOTALS	\$ 1,565,727	\$ 188,412	\$ 133,953	\$ (54,459)		\$ 963,357	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	1999 BLAZER	1999	\$ 34,882	\$ 1,775	\$	\$ (1,775)	5	\$ 34,882	76
77	ADMINISTRATIVE	1999 MERCEDES	2001	53,242	1,775		(1,775)	5	53,241	77
78	ADMINISTRATIVE	2004 LEXUS	2004	43,476	2,850	8,695	5,845	5	26,085	78
79							0			79
80	TOTALS			\$ 131,600	\$ 6,400	\$ 8,695	\$ 2,295		\$ 114,208	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)	\$ 8,950,872	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 362,008	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 309,726	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (52,282)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 2,112,886	85

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

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

G. Construction-in-Progress

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

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A-RELATED PARTY

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: \$ 68,080 Description: RENT STORAGE

(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	ADMINISTRATIVE	2004 TOYOTA WAGON	\$ 534.00	\$ 6,408	17
18	ADMINISTRATIVE	2005 PORSCHE	#####	15,790	18
19					19
20					20
21	TOTAL		\$ #####	\$ 22,198	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.	<u>/2007</u>	\$ _____
13.	<u>/2008</u>	\$ _____
14.	<u>/2009</u>	\$ _____

* 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>THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES</p>		

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

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

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

	Service	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	39-3	hrs	\$		\$ 13	\$		\$ 13	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			9,088			9,088	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			41,095			41,095	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescripts				280,869		280,869	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Radiology,Respiratory,Lab, Other (specify): Med.supplies, Rental	39-3 39-3					60,471 85,188		60,471 85,188	13
14	TOTAL			\$		\$ 50,196	\$ 426,528		\$ 476,724	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 LAKEVIEW NURSING & REHABILITATION CENTER # 0026484 Report Period Beginning: 01/01/2006 Ending: 12/31/2006
 XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2006 (last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$ 498	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 100,000)	2,939,897		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	97,296		6
7	Other Prepaid Expenses	21,116		7
8	Accounts Receivable (owners or related parties)	1,188,802		8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 4,247,609	\$ 0	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	1,673,176		15
16	Equipment, at Historical Cost	1,697,326		16
17	Accumulated Depreciation (book methods)	(1,551,198)		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):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,819,304	\$ 0	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 6,066,913	\$ 0	25

		1	2	
		Operating	After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 1,079,599	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	18,387		28
29	Short-Term Notes Payable	3,217,663		29
30	Accrued Salaries Payable	130,331		30
31	Accrued Taxes Payable (excluding real estate taxes)	68,056		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 4,514,036	\$ 0	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
Other Long-Term Liabilities(specify):				
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 0	\$ 0	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 4,514,036	\$ 0	46
47	TOTAL EQUITY(page 18, line 24)	\$ 1,552,877	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 6,066,913	\$ 0	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,484,502	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,484,502	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	68,375	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 68,375	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$ 0	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 1,552,877	24 *

* This must agree with page 17, line 47.

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

1

	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 9,853,574	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 9,853,574	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	490,574	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 490,574	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 0	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	520	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 520	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	VENDING COMMISSIONS	2,188	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 2,188	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 10,346,856	30

2

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,644,267	31
32	Health Care	4,111,441	32
33	General Administration	2,544,258	33
	B. Capital Expense		
34	Ownership	1,403,823	34
	C. Ancillary Expense		
35	Special Cost Centers	476,724	35
36	Provider Participation Fee	97,968	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 10,278,481	40
41	Income before Income Taxes (line 30 minus line 40)**	68,375	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 68,375	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 LAKEVIEW NURSING & REHABILITATION CENTER

0026484

Report Period Beginning: 01/01/2006

Ending: 12/31/2006

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	1,778	2,115	\$ 95,385	\$ 45.10	1
2	Assistant Director of Nursing	3,079	3,331	119,918	36.00	2
3	Registered Nurses	46,542	49,641	1,285,447	25.89	3
4	Licensed Practical Nurses	13,036	14,172	313,351	22.11	4
5	CNAs & Orderlies	96,949	103,676	999,289	9.64	5
6	CNA Trainees					6
7	Licensed Therapist	440	452	13,752	30.42	7
8	Rehab/Therapy Aides	13,293	14,483	414,829	28.64	8
9	Activity Director	1,981	2,130	28,654	13.45	9
10	Activity Assistants	12,712	13,465	104,001	7.72	10
11	Social Service Workers	4,716	5,113	83,200	16.27	11
12	Dietician					12
13	Food Service Supervisor	2,259	2,348	47,638	20.29	13
14	Head Cook					14
15	Cook Helpers/Assistants	30,313	33,776	341,758	10.12	15
16	Dishwashers					16
17	Maintenance Workers	5,639	6,188	106,744	17.25	17
18	Housekeepers	31,773	33,970	329,263	9.69	18
19	Laundry	7,739	8,526	75,718	8.88	19
20	Administrator	4,035	4,172	296,412	71.05	20
21	Assistant Administrator	1,903	2,219	45,068	20.31	21
22	Other Administrative					22
23	Office Manager	1,981	2,086	79,049	37.90	23
24	Clerical	16,355	17,208	224,587	13.05	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,698	2,051	32,546	15.87	31
32	Other Health Care(specify)					32
33	Other(specify) <u>SEE ATTACHED</u>	14,362	15,641	336,352	21.50	33
34	TOTAL (lines 1 - 33)	312,583	336,763	\$ 5,372,961 *	\$ 15.95	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	\$ 21,207	1-3	35
36	Medical Director	MONTHLY	57,000	9-3	36
37	Medical Records Consultant	MONTHLY	4,576	10-3	37
38	Nurse Consultant	19	1,106	10-3	38
39	Pharmacist Consultant		0	10-3	39
40	Physical Therapy Consultant		0	10a-3	40
41	Occupational Therapy Consultant	43	2,351	10a-3	41
42	Respiratory Therapy Consultant		0	10a-3	42
43	Speech Therapy Consultant		0	10a-3	43
44	Activity Consultant	48	2,400	11-3	44
45	Social Service Consultant	46	2,359	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	156	\$ 90,999		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses		\$	10-3	50
51	Licensed Practical Nurses			10-3	51
52	Certified Nurse Assistants/Aides	1,183	27,261	10-3	52
53	TOTAL (lines 50 - 52)	1,183	\$ 27,261		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	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009	FY2010	FY2011
1		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2	PAINT/DECORATING 2004	2,443	3 YRS		408	814	814	407				
3	PAINT/DECORATING 2006	2,930	3 YRS				489	976	976	489		
4												
5												
6												
7												
8												
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20	TOTALS	\$ 5,373		\$	\$ 408	\$ 814	\$ 1,303	\$ 1,383	\$ 976	\$ 489	\$	\$

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 \$8409
- (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. \$ 1,972 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. \$ 97,968
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. \$ 18,944 Has any meal income been offset against related costs? N/A Indicate the amount. \$ _____
- (16) Travel and Transportation
 - a. Are there costs included for out-of-state travel? NO
If YES, attach a complete explanation.
 - b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
 - c. What percent of all travel expense relates to transportation of nurses and patients? 5%
 - d. Have vehicle usage logs been maintained? NO
 - e. Are all vehicles stored at the nursing home during the night and all other times when not in use? NO
 - f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? YES
 - g. Does the facility transport residents to and from day training? NO**
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? NO
Firm Name: _____ 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