

		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.

**I. IDPH Facility ID Number:** 0046169

**Facility Name:** Lakewood Nursing & Rehab Center

**Address:** 1112 North Eastern Avenue Plainfield 60544  
 Number City Zip Code

**County:** Will

**Telephone Number:** (815) 436-3400 **Fax #** (815) 436-1357

**HFS ID Number:** 300124869001

**Date of Initial License for Current Owners:** 02/01/03

**Type of Ownership:**

<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 type="checkbox"/> "Sub-S" Corp.	
	<input checked="" type="checkbox"/> Limited Liability Co.	
	<input type="checkbox"/> Trust	
	<input type="checkbox"/> Other _____	

**In the event there are further questions about this report, please contact:**  
**Name:** Steve Lavenda **Telephone Number:** (847) 236 - 1111

**II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER**

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/06 to 12/31/06 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

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

<b>Officer or Administrator of Provider</b>	(Signed) _____	(Date) _____
	(Type or Print Name) _____	
	(Title) _____	
<b>Paid Preparer</b>	(Signed) _____	(Date) _____
	(Print Name and Title) <u>Edward N. Slack, C.P.A.</u>	
	(Firm Name & Address) <u>Frost, Ruttenberg &amp; Rothblatt, P.C.</u> <u>111 Pfingsten Road, Suite 300 Deerfield, IL 60015</u>	
	(Telephone) <u>(847) 236-1111</u> Fax # <u>(847) 236-1155</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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lakewood Nursing & Rehab Center# 0046169 Report Period Beginning: 01/01/06 Ending: 12/31/06

## 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 10/23/06

	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>103</u>	Skilled (SNF)	<u>125</u>	<u>39,135</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>103</u>	TOTALS	<u>125</u>	<u>39,135</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>14,875</u>	<u>14,317</u>	<u>6,606</u>	<u>35,798</u>	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>14,875</u>	<u>14,317</u>	<u>6,606</u>	<u>35,798</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 91.47%

D. How many bed-hold days during this year were paid by the Department?

1 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.

(E.g., day care, "meals on wheels", outpatient therapy)

NoneF. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 &amp; 4 include expenses for services or investments not directly related to patient care?

YES  NO 

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES  NO 

I. On what date did you start providing long term care at this location?

Date started 2/1/2003

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

YES  Date 2/1/2003 NO 

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

YES  NO  If YES, enter number of beds certified 103 and days of care provided 6,335Medicare Intermediary National Government Services

## IV. ACCOUNTING BASIS

ACCRUAL  MODIFIED CASH\*  CASH\* Is your fiscal year identical to your tax year? YES  NO Tax Year: 12/31/06 Fiscal Year: 12/31/06

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lakewood Nursing & Rehab Center # 0046169 Report Period Beginning: 01/01/06 Ending: 12/31/06

**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	203,563	29,554	7,520	240,637		240,637	3,316	243,953		1
2	Food Purchase		175,411		175,411		175,411	(10,097)	165,314		2
3	Housekeeping	112,594	30,369		142,963		142,963	(2,664)	140,299		3
4	Laundry	50,361	23,183		73,544		73,544	(558)	72,986		4
5	Heat and Other Utilities			124,729	124,729		124,729	1,505	126,234		5
6	Maintenance	117,228	12	146,616	263,856		263,856	6,128	269,984		6
7	Other (specify):*							1,715	1,715		7
8	<b>TOTAL General Services</b>	<b>483,746</b>	<b>258,529</b>	<b>278,865</b>	<b>1,021,140</b>		<b>1,021,140</b>	<b>(654)</b>	<b>1,020,486</b>		<b>8</b>
	<b>B. Health Care and Programs</b>										
9	Medical Director			13,600	13,600		13,600		13,600		9
10	Nursing and Medical Records	2,132,591	155,600	1,850	2,290,041		2,290,041	1,238	2,291,279		10
10a	Therapy	179,132		1,116	180,248		180,248	144,216	324,464		10a
11	Activities	108,557	14,112	392	123,061		123,061		123,061		11
12	Social Services	123,574		1,031	124,605		124,605	8,049	132,654		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*							22,071	22,071		15
16	<b>TOTAL Health Care and Programs</b>	<b>2,543,854</b>	<b>169,712</b>	<b>17,989</b>	<b>2,731,555</b>		<b>2,731,555</b>	<b>175,574</b>	<b>2,907,129</b>		<b>16</b>
	<b>C. General Administration</b>										
17	Administrative	91,368			91,368		91,368	32,605	123,973		17
18	Directors Fees										18
19	Professional Services			305,659	305,659	(750)	304,909	(250,341)	54,568		19
20	Dues, Fees, Subscriptions & Promotions			40,572	40,572		40,572	(4,589)	35,983		20
21	Clerical & General Office Expenses	70,763	31,649	107,101	209,513		209,513	38,130	247,643		21
22	Employee Benefits & Payroll Taxes			461,883	461,883		461,883	(5,629)	456,254		22
23	Inservice Training & Education										23
24	Travel and Seminar			1,913	1,913		1,913	2,918	4,831		24
25	Other Admin. Staff Transportation			6,048	6,048		6,048	64	6,112		25
26	Insurance-Prop.Liab.Malpractice			88,583	88,583		88,583	584	89,167		26
27	Other (specify):*							21,078	21,078		27
28	<b>TOTAL General Administration</b>	<b>162,131</b>	<b>31,649</b>	<b>1,011,759</b>	<b>1,205,539</b>	<b>(750)</b>	<b>1,204,789</b>	<b>(165,180)</b>	<b>1,039,609</b>		<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	<b>3,189,731</b>	<b>459,890</b>	<b>1,308,613</b>	<b>4,958,234</b>	<b>(750)</b>	<b>4,957,484</b>	<b>9,740</b>	<b>4,967,224</b>		<b>29</b>

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Lakewood Nursing & Rehab Center #0046169 Report Period Beginning: 01/01/06 Ending: 12/31/06

## 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			48,792	48,792		48,792	177,128	225,920			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							232,295	232,295			32
33	Real Estate Taxes			73,202	73,202	750	73,952	1,284	75,236			33
34	Rent-Facility & Grounds			309,746	309,746		309,746	(302,982)	6,764			34
35	Rent-Equipment & Vehicles			2,009	2,009		2,009	1,253	3,262			35
36	Other (specify):*							18,208	18,208			36
37	<b>TOTAL Ownership</b>			433,749	433,749	750	434,499	127,186	561,685			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		395,604	481,649	877,253		877,253	(15,132)	862,121			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			56,393	56,393		56,393	2,310	58,703			42
43	Other (specify):*											43
44	<b>TOTAL Special Cost Centers</b>		395,604	538,042	933,646		933,646	(12,822)	920,824			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	3,189,731	855,494	2,280,404	6,325,629		6,325,629	124,104	6,449,733			45

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lakewood Nursing & Rehab Center

# 0046169

Report Period Beginning: 01/01/06

Ending: 12/31/06

**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	(5,766)	30		9
10	Interest and Other Investment Income	(79,679)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(695)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(60,744)	21		24
25	Fund Raising, Advertising and Promotional	(10,502)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(18)	21		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(8,935)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (166,339)		\$	30

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)	290,442		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ 290,442		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ 124,104		37

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

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

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

BHF USE ONLY					
48		49		50	51
					52

SEE ACCOUNTANTS' COMPILATION REPORT

NON-ALLOWABLE EXPENSES		
	Amount	Reference
1	Other Income	\$ (2,010) 21
2	Days Over	(38) 10
3	Theft Loss	(107) 21
4	Collection Expense	(189) 21
5	Non-Allowable Billing Service	(5,887) 19
6	Non-Allowable Legal Fees	(3,016) 19
7	Provider Participation Fee	2,310 42
8	Billing Co.	
9	Filing Fees	(250) 20
10	2006 Seminar Adjusted Out On 2005 Cost Report	250 24
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101	Total	(6,935) 101

## STATE OF ILLINOIS

Summary A

Facility Name &amp; ID Number Lakewood Nursing &amp; Rehab Center

# 0046169

Report Period Beginning:

01/01/06

Ending:

12/31/06

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	<b>A. General Services</b>													
1	Dietary			303				2,475	554		(16)		3,316	1
2	Food Purchase	(695)							(9,402)				(10,097)	2
3	Housekeeping										(2,664)		(2,664)	3
4	Laundry										(558)		(558)	4
5	Heat and Other Utilities			1,381			62		62				1,505	5
6	Maintenance			2,095	3,702		41		99		(209)	400	6,128	6
7	Other (specify):*				1,292			423					1,715	7
8	<b>TOTAL General Services</b>	<b>(695)</b>		<b>3,779</b>	<b>4,994</b>		<b>103</b>	<b>2,898</b>	<b>(8,687)</b>		<b>(3,446)</b>	<b>400</b>	<b>(654)</b>	<b>8</b>
	<b>B. Health Care and Programs</b>													
9	Medical Director													9
10	Nursing and Medical Records	(30)						13,253			(11,985)		1,238	10
10a	Therapy					142,572		1,644					144,216	10a
11	Activities													11
12	Social Services				1,977			6,072					8,049	12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*				265	18,855		2,951					22,071	15
16	<b>TOTAL Health Care and Programs</b>	<b>(30)</b>			<b>2,242</b>	<b>161,427</b>		<b>23,920</b>			<b>(11,985)</b>		<b>175,574</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative			1,349	2,992	4,739		22,565	960				32,605	17
18	Directors Fees													18
19	Professional Services	(8,903)		(188,242)		162	(53,386)		28				(250,341)	19
20	Fees, Subscriptions & Promotions	(10,752)	250	3,712		2,133	25		43				(4,589)	20
21	Clerical & General Office Expenses	(63,074)		7,756	85,050	714	19	6,360	1,305				38,130	21
22	Employee Benefits & Payroll Taxes				(2,384)					(2,815)	(430)		(5,629)	22
23	Inservice Training & Education													23
24	Travel and Seminar	250		2,343		298	27						2,918	24
25	Other Admin. Staff Transportation								64				64	25
26	Insurance-Prop.Liab.Malpractice			(333)		808	14		95				584	26
27	Other (specify):*				16,152	666		3,940	320				21,078	27
28	<b>TOTAL General Administration</b>	<b>(82,479)</b>	<b>250</b>	<b>(173,415)</b>	<b>101,810</b>	<b>9,520</b>	<b>(53,301)</b>	<b>32,865</b>	<b>2,815</b>	<b>(2,815)</b>	<b>(430)</b>		<b>(165,180)</b>	<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	<b>(83,204)</b>	<b>250</b>	<b>(169,636)</b>	<b>109,046</b>	<b>170,947</b>	<b>(53,198)</b>	<b>59,683</b>	<b>(5,872)</b>	<b>(2,815)</b>	<b>(15,862)</b>	<b>400</b>	<b>9,740</b>	<b>29</b>

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Lakewood Nursing & Rehab Center # 0046169 Report Period Beginning: 01/01/06 Ending: 12/31/06

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	(5,766)	170,780	6,666			184		21			5,243	177,128	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(79,679)	293,009	15,635		2,240	524		2			564	232,295	32
33	Real Estate Taxes			1,142			120		22				1,284	33
34	Rent-Facility & Grounds		(305,505)	2,523									(302,982)	34
35	Rent-Equipment & Vehicles			676		538			39				1,253	35
36	Other (specify):*		18,208										18,208	36
37	<b>TOTAL Ownership</b>	<b>(85,445)</b>	<b>176,492</b>	<b>26,642</b>		<b>2,778</b>	<b>828</b>		<b>84</b>			<b>5,807</b>	<b>127,186</b>	<b>37</b>
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers								1,159		(4,906)	(11,385)	(15,132)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee	2,310											2,310	42
43	Other (specify):*													43
44	<b>TOTAL Special Cost Centers</b>	<b>2,310</b>							<b>1,159</b>		<b>(4,906)</b>	<b>(11,385)</b>	<b>(12,822)</b>	<b>44</b>
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	<b>(166,339)</b>	<b>176,742</b>	<b>(142,994)</b>	<b>109,046</b>	<b>173,725</b>	<b>(52,370)</b>	<b>59,683</b>	<b>(4,629)</b>	<b>(2,815)</b>	<b>(20,768)</b>	<b>(5,178)</b>	<b>124,104</b>	<b>45</b>

Facility Name & ID Number Lakewood Nursing & Rehab Center

# 0046169

Report Period Beginning:

01/01/06

Ending:

12/31/06

**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
See Attached		See Attached		See Attached		
				Lakewood Plainfield Property LLC		Building Co.

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	\$ 305,505	Lakewood Plainfield Property LLC	100.00%	\$	\$ (305,505)	1
2	V	32 Interest	75,021	Lakewood Plainfield Property LLC	100.00%	368,030	293,009	2
3	V	20 Filing Fees		Lakewood Plainfield Property LLC	100.00%	250	250	3
4	V	30 Depreciation		Lakewood Plainfield Property LLC	100.00%	170,780	170,780	4
5	V	36 Amortization		Lakewood Plainfield Property LLC	100.00%	18,208	18,208	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		\$ 380,526			\$ 557,268	\$ * 176,742	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lakewood Nursing & Rehab Center# 0046169Report Period Beginning: 01/01/06Ending: 12/31/06

## 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 Schedule V	2 Line	3 Cost Per General Ledger		4 Amount	5 Cost to Related Organization		6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item			Name of Related Organization					
15	V	01	Dietary	\$	Care Centers, Inc.	100.00%	\$ 303	303	15	
16	V	05	Utilities		Care Centers, Inc.	100.00%	1,381	1,381	16	
17	V	06	Maintenance		Care Centers, Inc.	100.00%	2,095	2,095	17	
18	V								18	
19	V	17	Administration		Care Centers, Inc.	100.00%	1,349	1,349	19	
20	V	19	Professional Fees	198,474	Care Centers, Inc.	100.00%	10,232	(188,242)	20	
21	V	20	Dues and Subscriptions		Care Centers, Inc.	100.00%	3,712	3,712	21	
22	V	21	Office & Clerical		Care Centers, Inc.	100.00%	7,756	7,756	22	
23	V	24	Travel and Seminar		Care Centers, Inc.	100.00%	2,343	2,343	23	
24	V	26	Insurance		Care Centers, Inc.	100.00%	(333)	(333)	24	
25	V	30	Depreciation		Care Centers, Inc.	100.00%	6,666	6,666	25	
26	V	32	Interest		Care Centers, Inc.	100.00%	15,635	15,635	26	
27	V	33	Real Estate Taxes		Care Centers, Inc.	100.00%	1,142	1,142	27	
28	V	34	Rent - Building		Care Centers, Inc.	100.00%	2,523	2,523	28	
29	V	35	Rent - Equipment and Auto		Care Centers, Inc.	100.00%	676	676	29	
30	V	25	Bus Reimbursement		Care Centers, Inc.	100.00%			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			\$ 198,474			\$ 55,480	\$ * (142,994)	39	

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lakewood Nursing & Rehab Center# 0046169Report Period Beginning: 01/01/06Ending: 12/31/06

## 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	06 Maintenance Salary		Care Centers, Inc.	100.00%	3,581	3,581	15
16	V	07 Emp. Ben. - Gen. Serv.		Care Centers, Inc.	100.00%	518	518	16
17	V	10 Nursing Salary		Care Centers, Inc.	100.00%			17
18	V	10a Rehab Salary		Care Centers, Inc.	100.00%			18
19	V	12 Social Service Salary		Care Centers, Inc.	100.00%	1,977	1,977	19
20	V	15 Emp. Ben. - Healthcare		Care Centers, Inc.	100.00%	265	265	20
21	V	17 Administration Salary		Care Centers, Inc.	100.00%	2,992	2,992	21
22	V	21 Office Salary		Care Centers, Inc.	100.00%	85,050	85,050	22
23	V	27 Emp. Ben. - Gen. Admin.		Care Centers, Inc.	100.00%	13,131	13,131	23
24	V							24
25	V	06 Maintenance Salary	2,622	Care Centers, Inc.	100.00%	2,743	121	25
26	V	07 Emp. Ben. - Gen. Serv.		Care Centers, Inc.	100.00%	774	774	26
27	V							27
28	V							28
29	V							29
30	V							30
31	V	17 Administration Salary		Care Centers, Inc.	100.00%			31
32	V	21 Office Salary	15,313	Care Centers, Inc.	100.00%	15,313		32
33	V	27 Emp. Ben. - Gen. Admin.		Care Centers, Inc.	100.00%	3,021	3,021	33
34	V							34
35	V	22 Employee Benefits	2,384				(2,384)	35
36	V							36
37	V							37
38	V							38
39	Total		\$ 20,319			\$ 129,365	\$ * 109,046	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

**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	10A THERAPY	\$	THERAPY WORKS REHAB. SERVICES, LLC	100.00%	\$ 142,572	142,572	15
16	V	15 HEALTHCARE EMP. BEN.				18,855	18,855	16
17	V	17 ADMINISTRATIVE				4,739	4,739	17
18	V	19 PROFESSIONAL FEES				162	162	18
19	V	20 DUES, FEES, SUBS				2,133	2,133	19
20	V	21 CLERICAL AND GENERAL				714	714	20
21	V	24 SEMINARS				298	298	21
22	V	26 INSURANCE				808	808	22
23	V	27 GEN ADMIN.- EMP. BEN.				666	666	23
24	V	32 INTEREST EXPENSE				2,240	2,240	24
25	V	35 EQUIPMENT RENTAL				538	538	25
26	V							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		\$			\$ 173,725	\$ * 173,725	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

**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	19	Professional Fees	\$	53,652			Care Centers Clinical, Inc.	100.00%	\$	266	\$	(53,386)		15
16	V	20	Dues and Subscriptions					Care Centers Clinical, Inc.	100.00%		25		25		16
17	V	21	Office and Clerical					Care Centers Clinical, Inc.	100.00%		19		19		17
18	V	24	Travel and Seminar					Care Centers Clinical, Inc.	100.00%		27		27		18
19	V	30	Depreciation					Care Centers Clinical, Inc.	100.00%		184		184		19
20	V	32	Interest					Care Centers Clinical, Inc.	100.00%		524		524		20
21	V	05	Utilities					Care Centers Clinical, Inc.	100.00%		62		62		21
22	V	06	Maintenance					Care Centers Clinical, Inc.	100.00%		41		41		22
23	V	26	Insurance					Care Centers Clinical, Inc.	100.00%		14		14		23
24	V	33	Real Estate Taxes					Care Centers Clinical, Inc.	100.00%		120		120		24
25	V														25
26	V														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			\$	53,652					\$	1,282	\$ *	(52,370)		39

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

SEE ACCOUNTANTS' COMPILATION REPORT

**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	01	Dietary Salary	\$	Care Centers Clinical, Inc.	100.00%	\$ 2,475	\$ 2,475	15
16	V	07	Emp. Ben. - Gen. Serv.		Care Centers Clinical, Inc.	100.00%	423	423	16
17	V	10	Nursing Salary		Care Centers Clinical, Inc.	100.00%	13,253	13,253	17
18	V	10a	Rehab Salary		Care Centers Clinical, Inc.	100.00%	1,644	1,644	18
19	V	12	Social Service Salary		Care Centers Clinical, Inc.	100.00%	6,072	6,072	19
20	V	15	Emp. Ben. - Healthcare		Care Centers Clinical, Inc.	100.00%	2,951	2,951	20
21	V	17	Administration Salary		Care Centers Clinical, Inc.	100.00%	22,565	22,565	21
22	V	21	Office Salary		Care Centers Clinical, Inc.	100.00%	6,360	6,360	22
23	V	27	Emp. Ben. - Gen. Admin.		Care Centers Clinical, Inc.	100.00%	3,940	3,940	23
24	V								24
25	V								25
26	V								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		\$				\$ 59,683	\$ * 59,683	39

\* 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 Schedule V	2 Line	3 Cost Per General Ledger		4 Amount	5 Cost to Related Organization		6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item			Name of Related Organization					
15	V	01	Dietary	\$	Care Centers Health Systems	100.00%	\$ 554	\$ 554	15	
16	V	02	Food	10,031	Care Centers Health Systems	100.00%	629	(9,402)	16	
17	V	05	Utilities		Care Centers Health Systems	100.00%	62	62	17	
18	V	06	Maintenance		Care Centers Health Systems	100.00%	99	99	18	
19	V	17	Administration		Care Centers Health Systems	100.00%	145	145	19	
20	V	19	Professional Fees		Care Centers Health Systems	100.00%	28	28	20	
21	V	20	Dues & Subscriptions		Care Centers Health Systems	100.00%	43	43	21	
22	V	21	Office & Clerical		Care Centers Health Systems	100.00%	91	91	22	
23	V	25	Auto Expenses		Care Centers Health Systems	100.00%	64	64	23	
24	V	26	Insurance		Care Centers Health Systems	100.00%	95	95	24	
25	V	30	Depreciation		Care Centers Health Systems	100.00%	21	21	25	
26	V	32	Interest Expense		Care Centers Health Systems	100.00%	2	2	26	
27	V	33	Real Estate Taxes		Care Centers Health Systems	100.00%	22	22	27	
28	V	35	Rent - Equipment & Auto		Care Centers Health Systems	100.00%	39	39	28	
29	V	39	Ancillary Enteral Supplies	4,808	Care Centers Health Systems	100.00%	5,967	1,159	29	
30	V	17	Administrative-Salary		Care Centers Health Systems	100.00%	815	815	30	
31	V	21	Office & Clerical-Salary		Care Centers Health Systems	100.00%	1,214	1,214	31	
32	V	27	Emp. Ben. - Gen. Admin.		Care Centers Health Systems	100.00%	320	320	32	
33	V								33	
34	V								34	
35	V								35	
36	V								36	
37	V								37	
38	V								38	
39	Total			\$ 14,839			\$ 10,210	\$ * (4,629)	39	

\* 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	22 EMPLOYEE HEALTH INSURANCE	\$	CCS EMPLOYEE BENEFIT GROUP	100.00%	\$ 139,029	\$ 139,029	15
16	V							16
17	V							17
18	V							18
19	V	22 EMPLOYEE HEALTH INSURANCE	141,844	CCS EMPLOYEE BENEFIT GROUP	100.00%		(141,844)	19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							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		\$ 141,844			\$ 139,029	\$ * (2,815)	39

\* 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	01 Dietary	\$ 198	Xcel Supply, LLC	100.00%	\$ 182	\$ (16)	15
16	V	03 Housekeeping	32,849	Xcel Supply, LLC	100.00%	30,185	(2,664)	16
17	V	04 Laundry	6,876	Xcel Supply, LLC	100.00%	6,318	(558)	17
18	V	06 Repairs & Maintenance	2,574	Xcel Supply, LLC	100.00%	2,365	(209)	18
19	V	10 Nursing	147,787	Xcel Supply, LLC	100.00%	135,802	(11,985)	19
20	V	11 Activities		Xcel Supply, LLC	100.00%			20
21	V	12 Social Service		Xcel Supply, LLC	100.00%			21
22	V	20 Dues, Fees, Subscriptions & Promotions		Xcel Supply, LLC	100.00%			22
23	V	21 Clerical & General Office		Xcel Supply, LLC	100.00%			23
24	V	22 Employee Benefits	5,303	Xcel Supply, LLC	100.00%	4,873	(430)	24
25	V	24 Seminars & Education		Xcel Supply, LLC	100.00%			25
26	V	39 Ancillary	60,496	Xcel Supply, LLC	100.00%	55,590	(4,906)	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		\$ 256,083			\$ 235,316	\$ * (20,768)	39

\* 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	06 Repairs	\$	Vent Lease, LLC.	100.00%	\$ 400	\$ 400	15
16	V	30 Depreciation		Vent Lease, LLC.	100.00%	5,243	5,243	16
17	V	32 Interest		Vent Lease, LLC.	100.00%	564	564	17
18	V	39 Vent/Ancillary Reimbursement	11,385	Vent Lease, LLC.	100.00%		(11,385)	18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							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		\$ 11,385			\$ 6,207	\$ * (5,178)	39

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

Facility Name & ID Number Lakewood Nursing & Rehab Center # 0046169 Report Period Beginning: 01/01/06 Ending: 12/31/06

## 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	Eric Rothner	Owner	Administrative	1.00%	See Attached	0.75	1.62%	Alloc Salary	\$ 1,227	17-7	1
2	Gale Rothner	Relative	Administrative	N/A	See Attached	0.79	2.25%	Alloc Salary	1,753	17-7	2
3	Mark Steinberg	Relative	Administrative	N/A	See Attached	1.24	2.25%	Alloc Salary	3,002	17-7	3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 5,982		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.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lakewood Nursing & Rehab Center

# 0046169

Report Period Beginning: 01/01/06

Ending: 12/31/06

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 \_\_\_\_\_  
 Street Address \_\_\_\_\_  
 City / State / Zip Code \_\_\_\_\_  
 Phone Number ( ) \_\_\_\_\_  
 Fax Number ( ) \_\_\_\_\_

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					\$	\$		\$	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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lakewood Nursing & Rehab Center

# 0046169

Report Period Beginning:

01/01/06

Ending: 12/31/06

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 Care Centers, Inc.  
 Street Address 2201 West Main Street  
 City / State / Zip Code Evanston, Illinois 60202  
 Phone Number ( 847) 905-3000  
 Fax Number ( 847) 905-3030

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	01	Dietary	Patient Days	1,592,658	31	\$ 13,468	\$ 35,798	\$ 303	1
2	05	Utilities	Patient Days	1,592,658	31	61,456	35,798	1,381	2
3	06	Maintenance	Patient Days	1,592,658	31	93,209	35,798	2,095	3
4									4
5	17	Administration	Patient Days	1,592,658	31	60,000	35,798	1,349	5
6	19	Professional Fees	Patient Days	1,592,658	31	455,203	35,798	10,232	6
7	20	Dues and Subscriptions	Patient Days	1,592,658	31	165,158	35,798	3,712	7
8	21	Office & Clerical	Patient Days	1,592,658	31	345,085	35,798	7,756	8
9	24	Travel and Seminar	Patient Days	1,592,658	31	104,250	35,798	2,343	9
10	26	Insurance	Patient Days	1,592,658	31	(14,814)	35,798	(333)	10
11	30	Depreciation	Patient Days	1,592,658	31	296,584	35,798	6,666	11
12	32	Interest	Patient Days	1,592,658	31	695,586	35,798	15,635	12
13	33	Real Estate Taxes	Patient Days	1,592,658	31	50,799	35,798	1,142	13
14	34	Rent - Building	Patient Days	1,592,658	31	112,256	35,798	2,523	14
15	35	Rent - Equipment & Auto	Patient Days	1,592,658	31	30,066	35,798	676	15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 2,468,306	\$	\$ 55,480	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lakewood Nursing & Rehab Center

# 0046169

Report Period Beginning: 01/01/06

Ending: 12/31/06

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 Care Centers, Inc.  
 Street Address 2201 West Main Street  
 City / State / Zip Code Evanston, Illinois 60202  
 Phone Number ( 847) 905-3000  
 Fax Number ( 847) 905-3030

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	06	Maintenance Salary	Patient Days	1,592,658	31	159,318	159,318	35,798	3,581	1
2	07	Emp. Ben. - Gen. Serv.	Patient Days	1,592,658	31	23,038		35,798	518	2
3	10	Nursing Salary	Patient Days	1,592,658	31			35,798		3
4	10a	Rehab Salary	Patient Days	1,592,658	31			35,798		4
5	12	Social Service Salary	Patient Days	1,592,658	31	87,938	87,938	35,798	1,977	5
6	15	Emp. Ben. - Healthcare	Patient Days	1,592,658	31	11,794		35,798	265	6
7	17	Administration Salary	Patient Days	1,592,658	31	133,122	133,122	35,798	2,992	7
8	21	Office Salary	Patient Days	1,592,658	31	3,783,895	3,783,895	35,798	85,050	8
9	27	Emp. Ben. - Gen. Admin.	Patient Days	1,592,658	31	584,195		35,798	13,131	9
10										10
11	06	Maintenance Salary	Direct Allocation		26	366,540	366,540		2,743	11
12	07	Emp. Ben. - Gen. Serv.	Direct Allocation		26	60,795			774	12
13										13
14										14
15										15
16										16
17										17
18	21	Office Salary	Direct Allocation		23	418,249	418,249		15,313	18
19	27	Emp. Ben. - Gen. Admin.	Direct Allocation		23	70,744			3,021	19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 5,699,628	\$ 4,949,062		\$ 129,365	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lakewood Nursing & Rehab Center

# 0046169

Report Period Beginning:

01/01/06

Ending: 12/31/06

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   THERAPY WORKS REHAB. SERVICES, LLC    
 Street Address   2201 WEST MAIN STREET    
 City / State / Zip Code   EVANSTON, ILLINOIS 60202    
 Phone Number   ( 847) 922-0702    
 Fax Number   ( 847) 905-4040  

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	10A	THERAPY	THERAPY WORKS FEES	1,681,285	9	\$ 1,341,785	\$ 1,262,093	284,409	\$ 142,572	1
2	15	HEALTHCARE EMP. BEN.	THERAPY WORKS FEES	1,681,285	9	177,453	284,409	284,409	18,855	2
3	17	ADMINISTRATIVE	THERAPY WORKS FEES	1,681,285	9	44,598	44,598	284,409	4,739	3
4	19	PROFESSIONAL FEES	THERAPY WORKS FEES	1,681,285	9	1,524	284,409	284,409	162	4
5	20	DUES, FEES, SUBS	THERAPY WORKS FEES	1,681,285	9	20,074	284,409	284,409	2,133	5
6	21	CLERICAL AND GENERAL	THERAPY WORKS FEES	1,681,285	9	6,717	284,409	284,409	714	6
7	24	SEMINARS	THERAPY WORKS FEES	1,681,285	9	2,806	284,409	284,409	298	7
8	26	INSURANCE	THERAPY WORKS FEES	1,681,285	9	7,608	284,409	284,409	808	8
9	27	GEN ADMIN.- EMP. BEN.	THERAPY WORKS FEES	1,681,285	9	6,264	284,409	284,409	666	9
10	32	INTEREST EXPENSE	THERAPY WORKS FEES	1,681,285	9	21,079	284,409	284,409	2,240	10
11	35	EQUIPMENT RENTAL	THERAPY WORKS FEES	1,681,285	9	5,067	284,409	284,409	538	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					\$ 1,634,975	\$ 1,306,691		\$ 173,725	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lakewood Nursing & Rehab Center

# 0046169

Report Period Beginning: 01/01/06

Ending: 12/31/06

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 Care Centers Clinical, Inc.  
 Street Address 2201 West Main Street  
 City / State / Zip Code Evanston, Illinois 60202  
 Phone Number ( 847) 905-3000  
 Fax Number ( 847) 905-3030

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	19	Professional Fees	Patient Days	1,592,658	30	\$ 11,820	\$ 35,798	\$ 266	1
2	20	Dues and Subscriptions	Patient Days	1,592,658	30	1,118	35,798	25	2
3	21	Office and Clerical	Patient Days	1,592,658	30	847	35,798	19	3
4	24	Travel and Seminar	Patient Days	1,592,658	30	1,201	35,798	27	4
5	30	Depreciation	Patient Days	1,592,658	30	8,167	35,798	184	5
6	32	Interest	Patient Days	1,592,658	30	23,321	35,798	524	6
7	05	Utilities	Patient Days	1,592,658	30	2,749	35,798	62	7
8	06	Maintenance	Patient Days	1,592,658	30	1,817	35,798	41	8
9	26	Insurance	Patient Days	1,592,658	30	623	35,798	14	9
10	33	Real Estate Taxes	Patient Days	1,592,658	30	5,358	35,798	120	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					\$ 57,020	\$	\$ 1,282	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lakewood Nursing & Rehab Center

# 0046169

Report Period Beginning:

01/01/06

Ending: 12/31/06

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 Care Centers Clinical, Inc.  
 Street Address 2201 West Main Street  
 City / State / Zip Code Evanston, Illinois 60202  
 Phone Number ( 847) 905-3000  
 Fax Number ( 847) 905-3030

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	01	Dietary Salary	Patient Days	1,592,658	30	110,093	110,093	35,798	2,475	1
2	07	Emp. Ben. - Gen. Serv.	Patient Days	1,592,658	30	18,826	18,826	35,798	423	2
3	10	Nursing Salary	Patient Days	1,592,658	30	589,608		35,798	13,253	3
4	10a	Rehab Salary	Patient Days	1,592,658	30	73,158	73,158	35,798	1,644	4
5	12	Social Service Salary	Patient Days	1,592,658	30	270,126	270,126	35,798	6,072	5
6	15	Emp. Ben. - Healthcare	Patient Days	1,592,658	30	131,280		35,798	2,951	6
7	17	Administration Salary	Patient Days	1,592,658	30	1,003,912		35,798	22,565	7
8	21	Office Salary	Patient Days	1,592,658	30	282,969	282,969	35,798	6,360	8
9	27	Emp. Ben. - Gen. Admin.	Patient Days	1,592,658	30	175,293		35,798	3,940	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					\$ 2,655,265	\$ 755,172		\$ 59,683	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lakewood Nursing & Rehab Center

# 0046169

Report Period Beginning:

01/01/06

Ending: 12/31/06

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 Care Centers Health Systems  
 Street Address 2201 West Main Street  
 City / State / Zip Code Evanston, Illinois 60202  
 Phone Number ( 847) 905-3000  
 Fax Number ( 847) 905-3030

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	01	Dietary	Billable Income	2,455,454	33	91,698	14,839	554	1
2	02	Food	Billable Income	2,455,454	33	104,128	14,839	629	2
3	05	Utilities	Billable Income	2,455,454	33	10,245	14,839	62	3
4	06	Maintenance	Billable Income	2,455,454	33	16,367	14,839	99	4
5	17	Administration	Billable Income	2,455,454	33	24,000	14,839	145	5
6	19	Professional Fees	Billable Income	2,455,454	33	4,618	14,839	28	6
7	20	Dues & Subscriptions	Billable Income	2,455,454	33	7,167	14,839	43	7
8	21	Office & Clerical	Billable Income	2,455,454	33	15,126	14,839	91	8
9	25	Auto Expenses	Billable Income	2,455,454	33	10,605	14,839	64	9
10	26	Insurance	Billable Income	2,455,454	33	15,802	14,839	95	10
11	30	Depreciation	Billable Income	2,455,454	33	3,557	14,839	21	11
12	32	Interest Expense	Billable Income	2,455,454	33	392	14,839	2	12
13	33	Real Estate Taxes	Billable Income	2,455,454	33	3,660	14,839	22	13
14	35	Rent - Equipment & Auto	Billable Income	2,455,454	33	6,478	14,839	39	14
15	39	Ancillary Enteral Supplies	Billable Income	2,455,454	33	987,356	14,839	5,967	15
16	17	Administrative-Salary	Billable Income	2,455,454	33	134,802	14,839	815	16
17	21	Office & Clerical-Salary	Billable Income	2,455,454	33	200,852	200,852	1,214	17
18	27	Emp. Ben. - Gen. Admin.	Billable Income	2,455,454	33	52,885	52,885	320	18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 1,689,738	\$ 253,738	\$ 10,210	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lakewood Nursing & Rehab Center

# 0046169

Report Period Beginning: 01/01/06

Ending: 12/31/06

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 CCS EMPLOYEE BENEFITS GROUP, INC.  
 Street Address 2201 MAIN STREET  
 City / State / Zip Code EVANSTON, IL 60202  
 Phone Number ( 847)905-4000  
 Fax Number ( 847)905-4040

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	22	EMPLOYEE HEALTH INSURANCE	DIRECT ALLOCATION		\$	\$		\$ 139,029	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				\$	\$		\$ 139,029	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lakewood Nursing & Rehab Center

# 0046169

Report Period Beginning: 01/01/06

Ending: 12/31/06

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 Xcel Supply, LLC  
 Street Address 2201 Main Street  
 City / State / Zip Code Evanston, IL 60202  
 Phone Number ( 847)328-7600  
 Fax Number ( 847)328-7615

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	01	Dietary			\$	\$		\$ 182	1
2	03	Housekeeping						30,185	2
3	04	Laundry						6,318	3
4	06	Repairs & Maintenance						2,365	4
5	10	Nursing						135,802	5
6	11	Activities							6
7	12	Social Service							7
8	20	Dues, Fees, Subscriptions & Prom							8
9	21	Clerical & General Office							9
10	22	Employee Benefits						4,873	10
11	24	Seminars & Education							11
12	39	Ancillary						55,590	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				\$	\$		\$ 235,316	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lakewood Nursing & Rehab Center

# 0046169

Report Period Beginning: 01/01/06

Ending: 12/31/06

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 Vent Lease, LLC  
 Street Address 2201 W. Main Street  
 City / State / Zip Code Evanston, Illinois 60202  
 Phone Number ( 847) 674-1180  
 Fax Number ( 847) 673-7741

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	06	Repairs	Direct Billing	868,537	31	\$ 30,521	\$ 11,385	\$ 400	1
2	30	Depreciation	Direct Billing	868,537	31	400,000	11,385	5,243	2
3	32	Interest	Direct Billing	868,537	31	43,063	11,385	564	3
4	39	Vent/Ancillary Reimbursement							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					\$ 473,584	\$	\$ 6,207	25

SEE ACCOUNTANTS' COMPILATION REPORT

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

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

1	2	3	4	5	6	7	8	9	10											
										Name of Lender	Related**		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	LaSalle Bank		X	Construction Loan			\$	748,501		\$	1									
2	Business Partners		X	Mortgage				5,103,972			2									
3	Rothner Health Ventures		X							24,833	3									
4	Hunter Management		X							13,783	4									
5	See Supplemental Schedule									694	5									
<b>Working Capital</b>																				
6											6									
7											7									
8	See Supplemental Schedule										8									
9	<b>TOTAL Facility Related</b>						\$	5,852,473		\$	368,030	9								
<b>B. Non-Facility Related*</b>																				
10	Interest Income		X							(79,679)	10									
11	Interest Inc. - Building Co.		X							(75,021)	11									
12	Care Centers Allocation		X							18,965	12									
13	See Supplemental Schedule										13									
14	<b>TOTAL Non-Facility Related</b>						\$			\$	(135,735)	14								
15	<b>TOTALS (line 9+line14)</b>						\$	5,852,473		\$	232,295	15								

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

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

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

Facility Name & ID Number Lakewood Nursing & Rehab Center # 0046169 Report Period Beginning: 01/01/06 Ending: 12/31/06

**IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE - SUPPLEMENTAL SCHEDULE**

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

1	2	3	4	5	6	7	8	9	10											
										Name of Lender	Related**		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	A.N.R. Inc		X				\$	\$		\$ 694	1									
2											2									
3											3									
4											4									
5											5									
6											6									
7	<b>TOTAL Long-Term</b>									<b>694</b>	7									
<b>Working Capital</b>																				
8							\$	\$		\$	8									
9											9									
10											10									
11											11									
12											12									
13											13									
14	<b>TOTAL Working Capital</b>										14									
<b>B. Non-Facility Related*</b>																				
15							\$	\$		\$	15									
16											16									
17											17									
18											18									
19											19									
20	<b>TOTAL Non-Facility Related</b>										20									

\* 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**

<p><b>Important</b>, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.</p>																											
1. Real Estate Tax accrual used on 2005 report.		\$ <b>48,800</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>60,786</b>	<b>2</b>																								
3. Under or (over) accrual (line 2 minus line 1).		\$ <b>11,986</b>	<b>3</b>																								
4. Real Estate Tax accrual used for 2006 report. (Detail and explain your calculation of this accrual on the lines below.)		\$ <b>62,500</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>750</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>75,236</b>	<b>7</b>																								
Real Estate Tax History:																											
Real Estate Tax Bill for Calendar Year:	<table border="1"> <tr><td>2001</td><td><u>52,662</u></td><td><u>8</u></td></tr> <tr><td>2002</td><td><u>45,196</u></td><td><u>9</u></td></tr> <tr><td>2003</td><td><u>43,903</u></td><td><u>10</u></td></tr> <tr><td>2004</td><td><u>46,430</u></td><td><u>11</u></td></tr> <tr><td>2005</td><td><u>59,502</u></td><td><u>12</u></td></tr> </table>	2001	<u>52,662</u>	<u>8</u>	2002	<u>45,196</u>	<u>9</u>	2003	<u>43,903</u>	<u>10</u>	2004	<u>46,430</u>	<u>11</u>	2005	<u>59,502</u>	<u>12</u>	<table border="1"> <tr><td colspan="2"><b>FOR BHF USE ONLY</b></td></tr> <tr><td><b>13</b></td><td>FROM R. E. TAX STATEMENT FOR 2005 \$</td></tr> <tr><td><b>14</b></td><td>PLUS APPEAL COST FROM LINE 5 \$</td></tr> <tr><td><b>15</b></td><td>LESS REFUND FROM LINE 6 \$</td></tr> <tr><td><b>16</b></td><td>AMOUNT TO USE FOR RATE CALCULATION \$</td></tr> </table>	<b>FOR BHF USE ONLY</b>		<b>13</b>	FROM R. E. TAX STATEMENT FOR 2005 \$	<b>14</b>	PLUS APPEAL COST FROM LINE 5 \$	<b>15</b>	LESS REFUND FROM LINE 6 \$	<b>16</b>	AMOUNT TO USE FOR RATE CALCULATION \$
2001	<u>52,662</u>	<u>8</u>																									
2002	<u>45,196</u>	<u>9</u>																									
2003	<u>43,903</u>	<u>10</u>																									
2004	<u>46,430</u>	<u>11</u>																									
2005	<u>59,502</u>	<u>12</u>																									
<b>FOR BHF USE ONLY</b>																											
<b>13</b>	FROM R. E. TAX STATEMENT FOR 2005 \$																										
<b>14</b>	PLUS APPEAL COST FROM LINE 5 \$																										
<b>15</b>	LESS REFUND FROM LINE 6 \$																										
<b>16</b>	AMOUNT TO USE FOR RATE CALCULATION \$																										
<b>2006 Accrual = \$59,502 x 1.05</b>																											
<b>Care Centers Allocation = \$1,284</b>																											

**NOTES:**

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

SEE ACCOUNTANTS' COMPILATION REPORT

**IMPORTANT NOTICE**

**TO:** Long Term Care Facilities with Real Estate Tax Rates **RE:** 2005 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 2005 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2005.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2005 real estate tax bill to Healthcare and Family Services, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

**Please send these items in with your completed 2006 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.

**2005 LONG TERM CARE REAL ESTATE TAX STATEMENT**

FACILITY NAME Lakewood Nursing & Rehab Center COUNTY Will

FACILITY IDPH LICENSE NUMBER 0046169

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE (847) 236-1111 FAX #: (847) 236-1155

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

Enter the tax index number and real estate tax assessed for 2005 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 2005.

(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>06-03-10-312-003-0000</u>	<u>Long Term Care Property</u>	\$ <u>59,501.82</u>	\$ <u>59,501.82</u>
2. <u>Home Office Allocation</u>	<u>See Attached</u>	\$ <u>116,388.47</u>	\$ <u>1,139.12</u>
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ <u>175,890.29</u>	\$ <u>60,640.94</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? X YES        NO

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

**C. Tax Bills**

Attach a copy of the original 2005 tax bills which were listed in Section A to this statement. Be sure to use the 2005 tax bill which is normally paid during 2006.

**PLEASE NOTE:** Payment information from the Internet or otherwise is not considered acceptable tax bill documentation. Facilities located in Cook County are required to provide copies of their original **second installment** tax bill.

**IMPORTANT NOTICE**

**TO:** Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

**Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed.** If you have any questions, please call the Office of Health Finance at (217) 782-1630.

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

FACILITY NAME Lakewood Nursing & Rehab Center COUNTY Will

FACILITY IDPH LICENSE NUMBER 0046169

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE (847) 236-1111 FAX #: (847) 236-1155

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

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. _____	_____	\$ _____	\$ _____
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ _____	\$ _____

**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        NO

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

**C. Tax Bills**

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

Facility Name & ID Number Lakewood Nursing & Rehab Center

# 0046169 Report Period Beginning:

01/01/06 Ending:

12/31/06

**X. BUILDING AND GENERAL INFORMATION:**

A. Square Feet: 15,925 B. General Construction Type: Exterior Brick Frame Steel Number of Stories 1

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).

None

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	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>Facility</u>	<u>273,121</u>	<u>2003</u>	<u>\$ 237,379</u>	1
2	<u>Care Centers Allocation</u>			<u>8,026</u>	2
3	<b>TOTALS</b>	<b>273,121</b>		<b>\$ 245,405</b>	<b>3</b>

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lakewood Nursing & Rehab Center

# 0046169

Report Period Beginning:

01/01/06

Ending:

12/31/06

**XI. OWNERSHIP COSTS (continued)**

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
<b>Improvement Type**</b>											
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
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27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

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

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

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lakewood Nursing & Rehab Center

# 0046169

Report Period Beginning:

01/01/06

Ending:

12/31/06

**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		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
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56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67		3,960,601	156,519		151,376	(5,143)	470,090	67
68		31,497	893		1,306	413	5,197	68
69			48,792			(48,792)		69
70		\$ 3,992,098	\$ 206,204		\$ 152,682	\$ (53,522)	\$ 475,287	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name &amp; ID Number Lakewood Nursing &amp; Rehab Center

# 0046169

Report Period Beginning:

01/01/06

Ending:

12/31/06

**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	<b>Totals from Page 12A, Carried Forward</b>		\$ 3,992,098	\$ 206,204		\$ 152,682	\$ (53,522)	\$ 475,287	1
2	Security System	2003	2,803		20	400	400	1,402	2
3	Hot Water Heater	2003	4,719		20	393	393	1,376	3
4	Hot Water Repair	2003	2,632		20	219	219	731	4
5	Plumbing Repair	2003	1,650		20	83	83	268	5
6	Water Heater	2004	3,295		20	275	275	801	6
7	Hot Water System	2004	1,270		20	64	64	148	7
8	Water Heater	2004	908		20	45	45	106	8
9	Smoke Dampers	2004	1,082		20	54	54	126	9
10	Compressor	2004	5,987		20	299	299	698	10
11	Generator	2004	1,181		20	169	169	394	11
12	Wall Heater	2004	818		20	68	68	148	12
13	Engineering Fees	2004	2,350		20	118	118	255	13
14	Nurse Call System - Call Cords	2004	607		20	30	30	91	14
15	Alarm - Transmitter	2004	516		20	26	26	71	15
16	Alarm - Controller / Receiver	2004	1,215		20	61	61	167	16
17	Overbed Lights	2004	656		20	33	33	87	17
18	Alarm Repairs	2004	557		20	28	28	74	18
19	Cubicle Curtains	2004	1,738		20	87	87	232	19
20	Roof Work	2004	1,665		20	83	83	215	20
21	Alarms	2004	763		20	38	38	99	21
22	New Locks	2004	729		20	36	36	82	22
23	Wall Unit - Circuit Board	2004	838		20	42	42	91	23
24	Electrical Relocation	2004	15,497		20	775	775	1,743	24
25	Dining Room Renovations	2005	3,000		20	150	150	288	25
26	Spinkler Heads	2005	6,000		20	857	857	1,071	26
27	Roof Repair	2005	1,750		20	88	88	146	27
28	Blinds	2005	1,885		20	94	94	110	28
29	Sprinkler	2005	1,957		20	98	98	106	29
30	Preferred Mechanical - Update Lobby/Office Ac System	2006	7,200		20	300	300	300	30
31	Noble Blacktop Serv. - Work On Parking Lot & Ramp	2006	8,825		20	368	368	368	31
32	Rf Technologies - Code Alert/Model 70	2006	10,393		20	520	520	520	32
33	Legat Architect - Additions & Alterations; Kitchen Redesign	2006	50,929		20	1,485	1,485	1,485	33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 4,137,513	\$ 206,204		\$ 160,068	\$ (46,136)	\$ 489,086	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Lakewood Nursing & Rehab Center

# 0046169

Report Period Beginning:

01/01/06

Ending:

12/31/06

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 12B, Carried Forward		\$ 4,137,513	\$ 206,204		\$ 160,068	\$ (46,136)	\$ 489,086	1
2	Alarm System	2006	8,817		20	525	525	525	2
3	Hth Telecommunications - New Phone & Lines In New Wing	2006	27,279		20	1,819	1,819	1,819	3
4	R&R Septic & Sewer Svc 06-5404	2006	3,750		20	63	63	63	4
5									5
6									6
7									7
8									8
9									9
10									10
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12									12
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25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 4,177,359	\$ 206,204		\$ 162,475	\$ (43,729)	\$ 491,493	34

SEE ACCOUNTANTS' COMPILATION REPORT

\*\*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 12C, Carried Forward	\$ 4,177,359	\$ 206,204		\$ 162,475	\$ (43,729)	\$ 491,493		1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)	\$ 4,177,359	\$ 206,204		\$ 162,475	\$ (43,729)	\$ 491,493		34

SEE ACCOUNTANTS' COMPILATION REPORT

\*\*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 12D, Carried Forward	\$ 4,177,359	\$ 206,204		\$ 162,475	\$ (43,729)	\$ 491,493		1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)	\$ 4,177,359	\$ 206,204		\$ 162,475	\$ (43,729)	\$ 491,493		34

SEE ACCOUNTANTS' COMPILATION REPORT

\*\*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 12E, Carried Forward	\$ 4,177,359	\$ 206,204		\$ 162,475	\$ (43,729)	\$ 491,493		1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)	\$ 4,177,359	\$ 206,204		\$ 162,475	\$ (43,729)	\$ 491,493		34

SEE ACCOUNTANTS' COMPILATION REPORT

\*\*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 12F, Carried Forward	\$ 4,177,359	\$ 206,204		\$ 162,475	\$ (43,729)	\$ 491,493		1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)	\$ 4,177,359	\$ 206,204		\$ 162,475	\$ (43,729)	\$ 491,493		34

SEE ACCOUNTANTS' COMPILATION REPORT

\*\*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	
1		\$ 4,177,359	\$ 206,204		\$ 162,475	\$ (43,729)	\$ 491,493	1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
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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)	\$ 4,177,359	\$ 206,204		\$ 162,475	\$ (43,729)	\$ 491,493	34

SEE ACCOUNTANTS' COMPILATION REPORT

\*\*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	
1		\$ 4,177,359	\$ 206,204		\$ 162,475	\$ (43,729)	\$ 491,493	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
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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)	\$ 4,177,359	\$ 206,204		\$ 162,475	\$ (43,729)	\$ 491,493	34

SEE ACCOUNTANTS' COMPILATION REPORT

\*\*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 12I, Carried Forward	\$ 4,177,359	\$ 206,204		\$ 162,475	\$ (43,729)	\$ 491,493		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
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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)	\$ 4,177,359	\$ 206,204		\$ 162,475	\$ (43,729)	\$ 491,493		34

SEE ACCOUNTANTS' COMPILATION REPORT

\*\*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 12J, Carried Forward	\$ 4,177,359	\$ 206,204		\$ 162,475	\$ (43,729)	\$ 491,493		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
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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)	\$ 4,177,359	\$ 206,204		\$ 162,475	\$ (43,729)	\$ 491,493		34

SEE ACCOUNTANTS' COMPILATION REPORT

\*\*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 12K, Carried Forward		\$ 4,177,359	\$ 206,204		\$ 162,475	\$ (43,729)	\$ 491,493	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
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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)		\$ 4,177,359	\$ 206,204		\$ 162,475	\$ (43,729)	\$ 491,493	34

SEE ACCOUNTANTS' COMPILATION REPORT

\*\*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	
1		\$ 4,177,359	\$ 206,204		\$ 162,475	\$ (43,729)	\$ 491,493	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								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34	TOTAL (lines 1 thru 33)	\$ 4,177,359	\$ 206,204		\$ 162,475	\$ (43,729)	\$ 491,493	34

SEE ACCOUNTANTS' COMPILATION REPORT

\*\*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 12M, Carried Forward	\$ 4,177,359	\$ 206,204		\$ 162,475	\$ (43,729)	\$ 491,493		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
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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)	\$ 4,177,359	\$ 206,204		\$ 162,475	\$ (43,729)	\$ 491,493		34

SEE ACCOUNTANTS' COMPILATION REPORT

\*\*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 12N, Carried Forward	\$ 4,177,359	\$ 206,204		\$ 162,475	\$ (43,729)	\$ 491,493		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
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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)	\$ 4,177,359	\$ 206,204		\$ 162,475	\$ (43,729)	\$ 491,493		34

SEE ACCOUNTANTS' COMPILATION REPORT

\*\*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 12O, Carried Forward		\$ 4,177,359	\$ 206,204		\$ 162,475	\$ (43,729)	\$ 491,493	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
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15									15
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19									19
20									20
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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)		\$ 4,177,359	\$ 206,204		\$ 162,475	\$ (43,729)	\$ 491,493	34

SEE ACCOUNTANTS' COMPILATION REPORT

\*\*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 12P, Carried Forward	\$ 4,177,359	\$ 206,204		\$ 162,475	\$ (43,729)	\$ 491,493		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
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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)	\$ 4,177,359	\$ 206,204		\$ 162,475	\$ (43,729)	\$ 491,493		34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Lakewood Nursing & Rehab Center

# 0046169

Report Period Beginning:

01/01/06

Ending:

12/31/06

**XI. OWNERSHIP COSTS (continued)**

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

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	125		2003	1971	\$ 1,915,178	\$ 49,105	39	\$ 49,105	\$	\$ 196,426	4
5											5
6											6
7											7
8											8
	<b>Improvement Type**</b>										
9		Lakewood Plainfield Property		2003	691,221	72,692	20	34,561	(38,131)	138,244	9
10		Construction Project		2005	1,354,202	34,722	20	67,710	32,988	135,420	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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Lakewood Nursing & Rehab Center

# 0046169

Report Period Beginning:

01/01/06

Ending:

12/31/06

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		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67								67
68								68
69								69
70	TOTAL (lines 4 thru 69)	\$ 3,960,601	\$ 156,519		\$ 151,376	\$ (5,143)	\$ 470,090	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Lakewood Nursing & Rehab Center

# 0046169

Report Period Beginning:

01/01/06

Ending:

12/31/06

**XI. OWNERSHIP COSTS (continued)**

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

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4		2201 Main LLC Allocation	2002	2002	\$ 9,832	\$ 252		\$ 252	\$	\$ 1,082	4
5		Care Centers Clinical Allocation	2002	2002	1,037	27		27		114	5
6		Care Centers Health Systems Allocation	2002	2002	190	5		5		21	6
7											7
8											8
<b>Improvement Type**</b>											
9		2201 Main LLC Allocation		2002	8,122	338	20	406	68	1,827	9
10		2201 Main LLC Allocation		2003	9,572	182	20	479	297	1,675	10
11		2201 Main LLC Allocation		2005	476	21	20	24	3	36	11
12											12
13		Care Centers Clinical Allocation		2002	857	36	20	43	7	193	13
14		Care Centers Clinical Allocation		2003	1,010	19	20	50	31	177	14
15		Care Centers Clinical Allocation		2005	50	2	20	3	1	4	15
16											16
17		Care Centers Health Systems Allocation		2002	157	7	20	8	1	35	17
18		Care Centers Health Systems Allocation		2003	185	4	20	9	5	32	18
19		Care Centers Health Systems Allocation		2005	9	-	20	-		1	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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Lakewood Nursing & Rehab Center

# 0046169

Report Period Beginning:

01/01/06

Ending:

12/31/06

**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		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67								67
68								68
69								69
70	<b>TOTAL (lines 4 thru 69)</b>	\$	\$		\$	\$	\$	70
			31,497	893	1,306	413	5,197	

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Lakewood Nursing & Rehab Center # 0046169 Report Period Beginning: 01/01/06 Ending: 12/31/06

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	\$ 278,176	\$ 25,188	\$ 41,007	\$ 15,819	10	\$ 135,222	71
72	Current Year Purchases	148,837	33	21,047	21,014	10	21,047	72
73	Fully Depreciated Assets	7,225				10	7,225	73
74								74
75	TOTALS	\$ 434,238	\$ 25,221	\$ 62,054	\$ 36,833		\$ 163,494	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	Care Centers, Inc.	Allocation	1900	\$ 16,163	\$ 196	\$ 1,326	\$ 1,130	5	\$ 11,563	76
77	Care Centers Clinical	Allocation	1900	983	67	67		5	67	77
78										78
79										79
80	TOTALS			\$ 17,146	\$ 263	\$ 1,393	\$ 1,130		\$ 11,630	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)	\$ 4,874,148	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 231,688	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 225,922	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (5,766)	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 666,617	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.

SEE ACCOUNTANTS' COMPILATION REPORT

**XII. RENTAL COSTS**

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

1. Name of Party Holding Lease: N/A

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

If NO, see instructions.  YES  NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5	Storage Unit				4,241			5
6	Care Centers Allocation				2,523			6
7	TOTAL				\$ 6,764			7

10. Effective dates of current rental agreement:

Beginning \_\_\_\_\_

Ending \_\_\_\_\_

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

Fiscal Year Ending                      Annual Rent

12.	_____ /2007	\$ _____
13.	_____ /2008	\$ _____
14.	_____ /2009	\$ _____

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: \$ 3,262 Description: See Attached Schedule

(Attach a schedule detailing the breakdown of movable equipment)

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

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

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

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

**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>
--	---	--

**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	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

**C. CONTRACTUAL INCOME**

In the box below record the amount of income your facility received training 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.
- SEE ACCOUNTANTS' COMPILATION REPORT

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 - 03	hrs	\$		\$ 173,736	\$		\$ 173,736	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			81,681			81,681	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			214,747			214,747	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 02	# of prescripts				282,424		282,424	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): See Supplemental					11,485	113,180		124,665	13
14	TOTAL			\$		\$ 481,649	\$ 395,604		\$ 877,253	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.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name &amp; ID Number Lakewood Nursing &amp; Rehab Center

# 0046169

Report Period Beginning: 01/01/06

Ending:

12/31/06

## XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/06

(last day of reporting year)

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

		1 Operating	2 After Consolidation*	
<b>A. Current Assets</b>				
1	Cash on Hand and in Banks	\$ 625	\$ 3,998	1
2	Cash-Patient Deposits	27,760	27,760	2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance )	1,041,676	1,047,528	3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	12,260	12,260	6
7	Other Prepaid Expenses	20,964	20,964	7
8	Accounts Receivable (owners or related parties)	1,491,621	(1,406,559)	8
9	Other(specify): <a href="#">See Attached Schedule</a>	20,265	20,265	9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 2,615,171	\$ (273,784)	10
<b>B. Long-Term Assets</b>				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		237,379	13
14	Buildings, at Historical Cost		9,062,437	14
15	Leasehold Improvements, at Historical Cost	70,028	70,028	15
16	Equipment, at Historical Cost	304,175	304,175	16
17	Accumulated Depreciation (book methods)	(81,062)	(910,577)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs		91,519	19
20	Accumulated Amortization - Organization & Pre-Operating Costs		(40,372)	20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <a href="#">See Attached Schedule</a>		38,690	23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 293,141	\$ 8,853,279	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 2,908,312	\$ 8,579,495	25

		1 Operating	2 After Consolidation*	
<b>C. Current Liabilities</b>				
26	Accounts Payable	\$ 692,785	\$ 926,685	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	20,569	20,569	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	243,773	243,773	30
31	Accrued Taxes Payable (excluding real estate taxes)	10,369	10,369	31
32	Accrued Real Estate Taxes(Sch.IX-B)	62,500	62,500	32
33	Accrued Interest Payable		161,608	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
<b>Other Current Liabilities(specify):</b>				
36	<a href="#">See Attached Schedule</a>	309,307	309,307	36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 1,339,303	\$ 1,734,811	38
<b>D. Long-Term Liabilities</b>				
39	Long-Term Notes Payable			39
40	Mortgage Payable		5,852,473	40
41	Bonds Payable			41
42	Deferred Compensation			42
<b>Other Long-Term Liabilities(specify):</b>				
43	<a href="#">See Attached Schedule</a>			43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$	\$ 5,852,473	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 1,339,303	\$ 7,587,284	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 1,569,009	\$ 992,211	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 2,908,312	\$ 8,579,495	48

SEE ACCOUNTANTS' COMPILATION REPORT

\*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,370,649	1
2	Restatements (describe):		2
3	<u>Rounding</u>	(2)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,370,647	6
<b>A. Additions (deductions):</b>			
7	NET Income (Loss) (from page 19, line 43)	527,060	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	(328,698)	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)	\$ 198,362	17
<b>B. Transfers (Itemize):</b>			
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 1,569,009	24 *

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lakewood Nursing & Rehab Center# 0046169Report Period Beginning: 01/01/06Ending: 12/31/06**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	\$ 6,573,635	1
2	Discounts and Allowances for all Levels	(1,993,460)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 4,580,175	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,793,605	6
7	Oxygen	80	7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 1,793,685	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	3,482	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	275,060	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	77,706	19
20	Radiology and X-Ray	12,135	20
21	Other Medical Services	28,721	21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 397,104	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	79,679	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 79,679	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<u>See Supplemental Schedule</u>	2,046	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 2,046	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 6,852,689	30

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	1,021,140	31
32	Health Care	2,731,555	32
33	General Administration	1,205,539	33
<b>B. Capital Expense</b>			
34	Ownership	433,749	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	877,253	35
36	Provider Participation Fee	56,393	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 6,325,629	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	527,060	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 527,060	43

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

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

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

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

Facility Name & ID Number Lakewood Nursing & Rehab Center

# 0046169

Report Period Beginning:

01/01/06

Ending:

12/31/06

**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	1,886	2,147	\$ 74,541	\$ 34.72	1
2	Assistant Director of Nursing	1,690	1,785	48,845	27.36	2
3	Registered Nurses	22,258	24,798	671,143	27.06	3
4	Licensed Practical Nurses	15,386	17,006	386,777	22.74	4
5	CNAs & Orderlies	69,817	79,558	906,502	11.39	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	9,549	10,734	179,132	16.69	8
9	Activity Director	1,908	2,171	46,534	21.43	9
10	Activity Assistants	6,971	7,382	62,023	8.40	10
11	Social Service Workers	6,091	6,624	123,574	18.66	11
12	Dietician					12
13	Food Service Supervisor	1,941	2,182	41,661	19.09	13
14	Head Cook					14
15	Cook Helpers/Assistants	5,410	5,785	74,385	12.86	15
16	Dishwashers	10,193	10,799	87,517	8.10	16
17	Maintenance Workers	6,526	7,171	117,228	16.35	17
18	Housekeepers	12,364	13,592	112,594	8.28	18
19	Laundry	3,276	3,619	50,361	13.92	19
20	Administrator	1,854	2,041	91,368	44.77	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	5,795	6,432	70,763	11.00	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	2,452	2,529	44,783	17.71	31
32	Other Health Care(specify)					32
33	Other(specify) <u>See Supplemental</u>					33
34	TOTAL (lines 1 - 33)	185,367	206,355	\$ 3,189,731 *	\$ 15.46	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	168	\$ 7,520	01-03	35
36	Medical Director	Monthly	13,600	09-03	36
37	Medical Records Consultant	Monthly	455	10-03	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	1,395	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	8	392	11-03	44
45	Social Service Consultant	Allocation	1,031	12-03	45
46	Other(specify) <u>Therapy Consult.</u>	28	1,116	10a-03	46
47					47
48					48
49	TOTAL (lines 35 - 48)	204	\$ 25,509		49

**C. CONTRACT NURSES**

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

SEE ACCOUNTANTS' COMPILATION REPORT



Facility Name & ID Number Lakewood Nursing & Rehab Center

Report Period Beginning: 01/01/06 Ending:

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

	1 Improvement Type	2 Month & Year Improvement Was Made	3 Total Cost	4 Useful Life	Amount of Expense Amortized Per Year								
					5 FY2003	6 FY2004	7 FY2005	8 FY2006	9 FY2007	10 FY2008	11 FY2009	12 FY2010	13 FY2011
1	N/A		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	<b>TOTALS</b>		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? No  
If YES, give association name and amount. \_\_\_\_\_
- (3) Did the nursing home make political contributions or payments to a political action organization? 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? Yes
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes  
What was the average life used for new equipment added during this period? 10 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 67,258 Line 10
- (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. \$ 58,703  
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. \$ \_\_\_\_\_ Has any meal income been offset against related costs? No 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? None  
d. Have vehicle usage logs been maintained? Yes  
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes  
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A  
**g. Does the facility transport residents to and from day training? No**  
**Indicate the amount of income earned from providing such transportation during this reporting period.** \$ \_\_\_\_\_
- (17) Has an audit been performed by an independent certified public accounting firm? No  
Firm Name: \_\_\_\_\_ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? \_\_\_\_\_ If no, please explain. \_\_\_\_\_
- (18) Have all costs which do not relate to the provision of long term care been adjusted out 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.

SEE ACCOUNTANTS' COMPILATION REPORT