



Facility Name & ID Number SOUTHVIEW MANOR

# 0038943 Report Period Beginning: 01/01/2006 Ending: 12/31/2006

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds \_\_\_\_\_

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	74	Skilled (SNF)	74	27,010	1
2		Skilled Pediatric (SNF/PED)			2
3	126	Intermediate (ICF)	126	45,990	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	200	TOTALS	200	73,000	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other		Total
8	SNF	39,509		3,358	42,867	8
9	SNF/PED					9
10	ICF	29,009		347	29,356	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	68,518		3,705	72,223	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 98.94%

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

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

NONE

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

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

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

I. On what date did you start providing long term care at this location?  
Date started 11/01/06

J. Was the facility purchased or leased after January 1, 1978?  
YES  Date 11/01/06 NO

K. Was the facility certified for Medicare during the reporting year?  
YES  NO  If YES, enter number of beds certified 42 and days of care provided 3,358

Medicare Intermediary ADMINISTAR FEDERAL

IV. ACCOUNTING BASIS

ACCRAUAL  MODIFIED CASH\*  CASH\*

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

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

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

Facility Name &amp; ID Number

SOUTHVIEW MANOR

# 0038943

Report Period Beginning:

01/01/2006

Ending:

12/31/2006

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

	Operating Expenses	Costs Per General Ledger				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	217,418	29,809	8,973	256,200		256,200	0	256,200		1
2	Food Purchase		255,145		255,145	0	255,145	(837)	254,308		2
3	Housekeeping	248,770	33,708	0	282,478		282,478	0	282,478		3
4	Laundry	60,978	14,798	8,504	84,280	0	84,280	1,630	85,910		4
5	Heat and Other Utilities			167,233	167,233		167,233	0	167,233		5
6	Maintenance	238,982	45,691	63,877	348,550		348,550	8,807	357,357		6
7	Other (specify):*			17,855	17,855		17,855	69	17,924		7
8	<b>TOTAL General Services</b>	<b>766,148</b>	<b>379,151</b>	<b>266,442</b>	<b>1,411,741</b>	<b>0</b>	<b>1,411,741</b>	<b>9,669</b>	<b>1,421,410</b>		<b>8</b>
	<b>B. Health Care and Programs</b>										
9	Medical Director	0		2,400	2,400		2,400	0	2,400		9
10	Nursing and Medical Records	1,765,090	61,459	9,270	1,835,819		1,835,819	0	1,835,819		10
10a	Therapy	18,710		302	19,012		19,012	0	19,012		10a
11	Activities	102,727	13,016	0	115,743		115,743	0	115,743		11
12	Social Services	154,288		7,421	161,709		161,709	0	161,709		12
13	CNA Training			0	0		0	0	0		13
14	Program Transportation			185	185		185	0	185		14
15	Other (specify):*			0	0		0	0	0		15
16	<b>TOTAL Health Care and Programs</b>	<b>2,040,815</b>	<b>74,475</b>	<b>19,578</b>	<b>2,134,868</b>	<b>0</b>	<b>2,134,868</b>	<b>0</b>	<b>2,134,868</b>		<b>16</b>
	<b>C. General Administration</b>										
17	Administrative	146,830		600,452	747,282		747,282	(196,933)	550,349		17
18	Directors Fees			0	0		0	0	0		18
19	Professional Services			61,752	61,752		61,752	12,096	73,848		19
20	Dues, Fees, Subscriptions & Promotions			19,003	19,003		19,003	4,281	23,284		20
21	Clerical & General Office Expenses	133,525	22,986	57,841	214,352		214,352	(18,821)	195,531		21
22	Employee Benefits & Payroll Taxes			578,539	578,539	0	578,539	0	578,539		22
23	Inservice Training & Education			0	0		0	0	0		23
24	Travel and Seminar			2,335	2,335		2,335	9	2,344		24
25	Other Admin. Staff Transportation			2,754	2,754		2,754	888	3,642		25
26	Insurance-Prop.Liab.Malpractice			102,728	102,728		102,728	536	103,264		26
27	Other (specify):*			306,739	306,739		306,739	(292,758)	13,981		27
28	<b>TOTAL General Administration</b>	<b>280,355</b>	<b>22,986</b>	<b>1,732,143</b>	<b>2,035,484</b>	<b>0</b>	<b>2,035,484</b>	<b>(490,702)</b>	<b>1,544,782</b>		<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	<b>3,087,318</b>	<b>476,612</b>	<b>2,018,163</b>	<b>5,582,093</b>	<b>0</b>	<b>5,582,093</b>	<b>(481,033)</b>	<b>5,101,060</b>		<b>29</b>

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

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

V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE	SCHED REF	TOTAL
1	<b>DIETARY</b>	
	DIETITIAN CONSULTANT XVIII B 35-2	8,973
	REPAIRS & MAINTENANCE	0
		0
		8,973
3	<b>HOUSEKEEPING</b>	
		0
		0
		0
4	<b>LAUNDRY</b>	
	EQUIPMENT REPAIRS & MAINTENANCE	8,504
		0
		8,504
5	<b>HEAT &amp; OTHER UTILITIES</b>	
	GAS HEAT	83,329
	ELECTRICITY	65,581
	WATER	18,323
	CABLE TV - LOBBY	0
		0
		167,233
6	<b>MAINTENANCE</b>	
	GROUNDS MAINTENANCE	225
	PAINTING & DECORATING	0
	BUILDING REPAIRS	0
	MAINTENANCE TRAVEL	0
	EQUIPMENT MAINTENANCE & REPAIR	29,766
	ELEVATOR MAINTENANCE & REPAIR	24,511
	OUTSIDE LABOR	0
	EXTERMINATING SERVICE	2,401
	FIRE SERVICE	6,974
		0
		0
		0
		0
		63,877
7	<b>OTHER</b>	
	SCAVENGER	17,855
	SECURITY SERVICE	0
		0
		0
		17,855
9	<b>MEDICAL DIRECTOR</b>	2,400
	MEDICAL DIRECTOR FEES XVIII B 36-2	2,400
		2,400

LINE	SCHED REF	TOTAL
10	<b>NURSING</b>	
	CONTRACT NURSING XVIII C 53-2	
	LABORATORY & XRAY EXPENSE	370
	PURCHASED SERVICES	0
	PSYCHO-SOCIAL CONSULTANT XVIII B ___-2	0
	RESTORATIVE NURSING CONSULTANT XVIII B 38-2	0
	MEDICAL RECORDS CONSULTANT XVIII B 37-2	0
	PHARMACY CONSULTANT XVIII B 39-2	2,500
	UTILIZATION REVIEW FEES XVIII B ___-2	0
	PHYSICIANS XVIII B ___-2	0
	PSYCHIATRIC XVIII B ___-2	4,800
	RN CONSULTANT XVIII B 38-2	0
	DENTAL CONSULTANT	1,600
		0
		9,270
10a	<b>THERAPY</b>	
	PHYSICAL THERAPY SERVICES	
	SPEECH THERAPY SERVICES	0
	OCCUPATIONAL THERAPY SERVICES	0
	REHABILITATION CONSULTANT XVIII B ___-2	0
	PHYSICAL THERAPY CONSULTANT XVIII B 40-2	0
	OCCUPATIONAL THERAPY CONSULTA XVIII B 41-2	302
	RESPIRATORY THERAPY CONSULTAN XVIII B 42-2	0
	SPEECH THERAPY CONSULTANT XVIII B 43-2	0
		302
11	<b>ACTIVITIES</b>	
	CABLE TV - PATIENT ROOMS	0
	ACTIVITY REHAB CONSULTANT XVIII B 44-2	0
		0
		0
		0
		0
		0
12	<b>SOCIAL SERVICES</b>	
	SOCIAL REHABILITATION SERVICES	0
	SOCIAL REHABILITATION CONSULTAN XVIII B 45-2	7,421
	SOCIAL WORKER XVIII B 45-2	0
		0
		7,421
13	<b>NURSE AIDE TRAINING</b>	
	NURSE AIDE TRAINING COSTS XIII	0
		0

V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE	SCHED REF	TOTAL
14	<b>PROGRAM TRANSPORTATION</b>	
	PATIENT TRANSPORTATION	185
17	<b>ADMINISTRATIVE</b>	
	MANAGEMENT FEES XIX B	600,452
	<b>DIRECTORS FEES</b>	
18	DIRECTORS FEES	0
19	<b>PROFESSIONAL SERVICES</b>	
	DATA PROCESSING XIX C	23,241
	ADMINISTRATIVE CONSULTANTS XIX C	0
	PROFESSIONAL FEES XIX C	38,511
		0
		61,752
20	<b>FEES,SUBSCRIPTIONS,PROMOTIONS</b>	
	ENTERTAINMENT & MARKETING VI 19 XIX F	0
	ADV & PROMO-NON PATIENT RELATED VI 25 XIX F	504
	EMPLOYEE WANT ADS XIX F	(900)
	CONTRIBUTIONS VI 20 XIX F	0
	DUES & SUBSCRIPTIONS XIX F	11,894
	LICENSES & PERMITS XIX F	5,405
	PUBLIC RELATIONS-PATIENT RELATED XIX F	0
	ADVERTISING-YELLOW PAGES VI 28 XIX F	0
	TRUST FEES / FRANCHISE TAX / ETC VI 17 XIX F	100
	CONTRIBUTIONS - POLITICAL VI 20 XIX F	0
	HEALTH CARE WORKER BACKGROUND CHEC XIX F	0
	PATIENT BACKGROUND CHECKS XIX F	2,000
		19,003
21	<b>CLERICAL &amp; GENERAL OFFICE EXPENSES</b>	
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)	2,586
	EQUIPMENT REPAIR & MAINTENANCE	0
	OUTSIDE CLERICAL SERVICES	17,000
	PENALTIES / OVERDRAFT CHARGES VI 18	264
	HOME OFFICE EXPENSE	0
	THEFT & DAMAGE LOSS	0
	TELEPHONE	37,991
	MESSENGER SERVICE	0
		0
		57,841

LINE	SCHED REF	TOTAL
22	<b>EMPLOYEE BENEFITS &amp; PAYROLL TAXES</b>	
	FICA TAXES XIX D	235,908
	UNEMPLOYMENT COMPENSATION XIX D	81,679
	WORKERS COMPENSATION INSURANC XIX D	68,822
	HOSPITALIZATION INSURANCE XIX D	180,544
	EMPLOYEE BENEFITS - OTHER XIX D	3,095
	EMPLOYEE PHYSICAL EXAMS XIX D	0
	INSURANCE - EXECUTIVE LIFE VI 21/XIX D	0
	PENSION/PROFIT SHARING PLANS XIX D	0
	CHICAGO HEAD TAX XIX D	8,491
		0
		578,539
23	<b>INSERVICE TRAINING &amp; EDUCATION</b>	
	EDUCATION & SEMINARS	0
		0
24	<b>TRAVEL &amp; SEMINARS</b>	
	EDUCATION & SEMINARS XIX G	2,335
	TRAVEL XIX G	0
		2,335
25	<b>ADMIN. STAFF TRANSPORTATION</b>	
	TRANSPORTATION - STAFF	2,754
		2,754
26	<b>INSURANCE - PROP. LIAB &amp; MALPRACTICE</b>	
	GENERAL INSURANCE	102,728
		102,728
27	<b>OTHER</b>	
	BAD DEBTS VI 24	306,739
		306,739

GRAND TOTAL COLUMN 3 OTHER

2,018,163

SOUTHVIEW MANOR  
 EMPLOYEE MEAL RECLASSIFICATION (PAGE 3 SCHEDULE V COLUMN 5 LINES 2 AND 22)  
 12/31/2006

TOTAL FOOD PURCHASE	255,145	PATIENT MEALS	216669
LESS SALES TAX	(837)	ADD EMPLOYEE MEALS	0
	-----		-----
NET FOOD	254,308	TOTAL MEALS/YEAR	216669
TOTAL PATIENT CENSUS	72,223	NET FOOD	254308
TIME 3 MEALS PER DAY	3	DIVIDE TOTAL MEALS/YEAR	216669
	-----		
TOTAL PATIENT MEALS	216669	COST PER MEAL	1.17
		TIME EMPLOYEE MEALS	0
ADD # EMPLOYEE MEALS/DAY			-----
TIME # DAYS	365	EMPLOYEE MEAL RECLASSIFICATION	0
	-----		=====
TOTAL EMPLOYEE MEALS	0		

Facility Name &amp; ID Number

SOUTHVIEW MANOR

#0038943

Report Period Beginning:

01/01/2006

Ending:

12/31/2006

## 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			242,521	242,521		242,521	(112,839)	129,682			30
31	Amortization of Pre-Op. & Org.			0	0		0	0	0			31
32	Interest			108,264	108,264		108,264	492,737	601,001			32
33	Real Estate Taxes			212,566	212,566		212,566	0	212,566			33
34	Rent-Facility & Grounds			928,791	928,791		928,791	(650,000)	278,791			34
35	Rent-Equipment & Vehicles			43,046	43,046		43,046	4,348	47,394			35
36	Other (specify):* goodwill, amort software			705,291	705,291		705,291	(699,600)	5,691			36
37	<b>TOTAL Ownership</b>			2,240,479	2,240,479	0	2,240,479	(965,354)	1,275,125			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation				0		0	0	0			38
39	Ancillary Service Centers		95,046	199,047	294,093		294,093	0	294,093			39
40	Barber and Beauty Shops				0		0	0	0			40
41	Coffee and Gift Shops				0		0	0	0			41
42	Provider Participation Fee			109,500	109,500		109,500	0	109,500			42
43	Other (specify):*				0		0	0	0			43
44	<b>TOTAL Special Cost Centers</b>	0	95,046	308,547	403,593	0	403,593	0	403,593			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	3,087,318	571,658	4,567,189	8,226,165	0	8,226,165	(1,446,387)	6,779,778			45

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

Facility Name & ID Number **SOUTHVIEW MANOR**

# **0038943**

Report Period Beginning:

**01/01/2006**

Ending:

**12/31/2006**

**VI. ADJUSTMENT DETAIL**

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

		1	2	3	
	<b>NON-ALLOWABLE EXPENSES</b>	<b>Amount</b>	<b>Refer- ence</b>	<b>OHF USE ONLY</b>	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(217,518)	30		9
10	Interest and Other Investment Income	(11)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(837)	2		13
14	Non-Care Related Interest	0	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees	(100)	20		17
18	Fines and Penalties	(264)	21		18
19	Entertainment	0	20		19
20	Contributions	0	20		20
21	Owner or Key-Man Insurance	0	22		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(306,739)	27		24
25	Fund Raising, Advertising and Promotional	(504)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	0	20		28
29	Other-Attach Schedule	(786,352)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	<b>\$ (1,312,325)</b>		<b>\$ 0</b>	<b>30</b>

<b>BHF USE ONLY</b>					
48	49	50	51	52	

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

		1	2	
		<b>Amount</b>	<b>Reference</b>	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(134,062)		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	<b>\$ (134,062)</b>		<b>36</b>
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	<b>\$ (1,446,387)</b>		<b>37</b>

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

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

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

## SOUTHVIEW MANOR

ID# 0038943

Report Period Beginning: 01/01/2006

Ending: 12/31/2006

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	DEFERRED MAINTENANCE	\$ 4,393	6	1
2	MARKETING SALARIES	(39,107)	21	2
3	BANK CHARGE	(2,586)	21	3
4	MANAGEMENT FEES - 6865 FINANCIAL ,INC	(49,452)	17	4
5	AMORTIZATION OF GOODWILL	(699,600)	36	5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	<b>Total</b>	(786,352)		49

## STATE OF ILLINOIS

Summary A

Facility Name & ID Number SOUTHVIEW MANOR# 0038943

Report Period Beginning:

01/01/2006

Ending:

12/31/2006**SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I**

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
		(to Sch V, col.7)												
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(837)	0	0	0	0	0	0	0	0	0	0	(837)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	1,630	0	0	0	0	0	0	0	0	1,630	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	4,393	2,244	2,170	0	0	0	0	0	0	0	0	8,807	6
7	Other (specify):*	0	0	69	0	0	0	0	0	0	0	0	69	7
8	<b>TOTAL General Services</b>	<b>3,556</b>	<b>2,244</b>	<b>3,869</b>	<b>0</b>	<b>9,669</b>	<b>8</b>							
	<b>B. Health Care and Programs</b>													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	<b>TOTAL Health Care and Programs</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative	(49,452)	(157,668)	10,187	0	0	0	0	0	0	0	0	(196,933)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	1,281	10,815	0	0	0	0	0	0	0	0	12,096	19
20	Fees, Subscriptions & Promotions	(604)	0	4,885	0	0	0	0	0	0	0	0	4,281	20
21	Clerical & General Office Expenses	(41,957)	13,001	10,135	0	0	0	0	0	0	0	0	(18,821)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	9	0	0	0	0	0	0	0	0	9	24
25	Other Admin. Staff Transportation	0	354	534	0	0	0	0	0	0	0	0	888	25
26	Insurance-Prop.Liab.Malpractice	0	205	331	0	0	0	0	0	0	0	0	536	26
27	Other (specify):*	(306,739)	6,250	7,731	0	0	0	0	0	0	0	0	(292,758)	27
28	<b>TOTAL General Administration</b>	<b>(398,752)</b>	<b>(136,577)</b>	<b>44,627</b>	<b>0</b>	<b>(490,702)</b>	<b>28</b>							
29	<b>TOTAL Operating Expense</b> <b>(sum of lines 8,16 &amp; 28)</b>	<b>(395,196)</b>	<b>(134,333)</b>	<b>48,496</b>	<b>0</b>	<b>(481,033)</b>	<b>29</b>							

## STATE OF ILLINOIS

Summary B

Facility Name & ID Number SOUTHVIEW MANOR# 0038943

Report Period Beginning:

01/01/2006

Ending:

12/31/2006

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	(217,518)	267	324	0	104,088	0	0	0	0	0	0	(112,839)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(11)	0	0	0	492,748	0	0	0	0	0	0	492,737	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	(650,000)	0	0	0	0	0	0	(650,000)	34
35	Rent-Equipment & Vehicles	0	507	3,841	0	0	0	0	0	0	0	0	4,348	35
36	Other (specify):*	(699,600)	0	0	0	0	0	0	0	0	0	0	(699,600)	36
37	<b>TOTAL Ownership</b>	<b>(917,129)</b>	<b>774</b>	<b>4,165</b>	<b>0</b>	<b>(53,164)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(965,354)</b>	<b>37</b>
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	<b>TOTAL Special Cost Centers</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>44</b>
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	<b>(1,312,325)</b>	<b>(133,559)</b>	<b>52,661</b>	<b>0</b>	<b>(53,164)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(1,446,387)</b>	<b>45</b>

Facility Name & ID Number

SOUTHVIEW MANOR

# 0038943

Report Period Beginning:

01/01/2006

Ending:

12/31/2006

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

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
1	V	17	MANAGEMNT FEES - EMI	\$ 172,000			\$	(172,000)	1
2	V	6	DRIVER'S SALARY			2,244		2,244	2
3	V	17	OFFICER'S SALARY			14,332		14,332	3
4	V	19	ACCOUNTING FEES			1,281		1,281	4
5	V	21	OFFICE EXPENSE			13,001		13,001	5
6	V	25	TRANSPORTATION			354		354	6
7	V	26	INSURANCE			205		205	7
8	V	27	EMPLOYEE BENEFITS			6,250		6,250	8
9	V	30	DEPRECIATION			267		267	9
10	V	35	AUTO LEASE			507		507	10
11	V								11
12	V								12
13	V								13
14	Total		\$ 172,000			\$ 38,441	\$ *	(133,559)	14

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	21 OUTSIDE CLERICAL	\$ 17,000			\$	\$(17,000)
16	V	4 HOUSEKEEPING SALARIES				1,630	1,630
17	V	6 PAINTERS SALARIES				2,170	2,170
18	V	7 SCAVENGER				69	69
19	V	17 CFO SALARY - A WEINFELD				10,187	10,187
20	V	19 PROFESSIONAL FEES				10,815	10,815
21	V	20 WANT ADS / BACKGR CKS				4,885	4,885
22	V	21 OFFICE EXPENSE				27,135	27,135
23	V	24 IN STATE TRAVEL				9	9
24	V	25 TRANSPORTATION				534	534
25	V	26 INSURANCE				331	331
26	V	27 EMPLOYEE BENEFITS				7,731	7,731
27	V	30 DEPRECIATION				324	324
28	V	35 EQUIPMENT RENT				3,841	3,841
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 17,000			\$ 69,661	\$ * 52,661

\* 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		\$			\$	\$	15
16	V							16
17	V							17
18	V							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	<b>Total</b>		\$			\$	0	\$ *

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

**VII. RELATED PARTIES (continued)**

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	34 RENT - E&N	\$ 650,000			\$	(650,000)
16	V	30 DEPRECIATION S.L.				104,088	104,088
17	V	32 INTEREST				313,711	313,711
18	V	32 INTEREST				179,037	179,037
19	V						
20	V						
21	V						
22	V						
23	V						
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 650,000			\$ 596,836	\$ * (53,164)

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

Facility Name &amp; ID Number

SOUTHVIEW MANOR

#

0038943

Report Period Beginning:

01/01/2006

Ending:

12/31/2006

## VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	MORRIS ESFORMES		ADMIN	32.34	SEE			SALARY	\$ 14,332	17-7	1
2					ATTACHED						2
3					SCHEDULE						3
4	PHILIP ESFORMES		ADMIN	32.33				MGMT FEE	172,000	17-8	4
5											5
6											6
7											7
8	SHELDON NEIDICH		ADMIN	32.33				MGMT FEE	207,000	17-8	8
9											9
10											10
11											11
12	AVRUM WEINFELD		CFO					SALARY	10,187	17-7	12
13								TOTAL	\$ 403,519		13

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

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

Facility Name & ID Number SOUTHVIEW MANOR

# 0038943

Report Period Beginning:

01/01/2006

Ending: 2/31/2006

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES  NO

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	6	DRIVER SALARY	PATIENT DAYS	778,042	14	\$ 28,965	\$ 60,276	\$ 2,244	1
2	17	OFFICER SALARY	PATIENT DAYS	778,042	14	185,000	60,276	14,332	2
3	19	ACCOUNTING FEES	PATIENT DAYS	778,042	14	16,537	60,276	1,281	3
4	21	OFFICE EXPENSE	PATIENT DAYS	778,042	14	167,811	60,276	13,001	4
5	25	TRANSPORTATION	PATIENT DAYS	778,042	14	4,565	60,276	354	5
6	26	INSURANCE	PATIENT DAYS	778,042	14	2,648	60,276	205	6
7	27	EMPLOYEE BENEFITS	PATIENT DAYS	778,042	14	80,669	60,276	6,250	7
8	30	DEPRECIATION	PATIENT DAYS	778,042	14	3,451	60,276	267	8
9	35	AUTO LEASE	PATIENT DAYS	778,042	14	6,544	60,276	507	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					\$ 496,190	\$ 345,993	\$ 38,441	25

Facility Name & ID Number **SOUTHVIEW MANOR**

# **0038943**

Report Period Beginning:

**01/01/2006**

Ending: **2/31/2006**

**VIII. ALLOCATION OF INDIRECT COSTS**

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES  NO

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

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

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	4	HOUSEKEEPING SALARIES	PATIENT DAYS	863,827	14	\$ 19,500	\$ 19,500	72,223	\$ 1,630	1
2	6	PAINTERS SALARIES	PATIENT DAYS	863,827	14	25,953	25,953	72,223	2,170	2
3	7	SCAVENGER	PATIENT DAYS	863,827	14	825		72,223	69	3
4	17	CFO SALARY -A. WEINFELD	PATIENT DAYS	863,827	14	121,844	121,844	72,223	10,187	4
5	19	PROFESSIONAL FEES	PATIENT DAYS	863,827	14	129,352	110,503	72,223	10,815	5
6	20	WANT ADS / BACKGR CKS	PATIENT DAYS	863,827	14	58,423		72,223	4,885	6
7	21	OFFICE EXPENSE	PATIENT DAYS	863,827	14	324,544	218,865	72,223	27,135	7
8	24	IN STATE TRAVEL	PATIENT DAYS	863,827	14	112		72,223	9	8
9	25	TRANSPORTATION	PATIENT DAYS	863,827	14	6,388		72,223	534	9
10	26	INSURANCE	PATIENT DAYS	863,827	14	3,958		72,223	331	10
11	27	EMPLOYEE BENEFITS	PATIENT DAYS	863,827	14	92,462		72,223	7,731	11
12	30	DEPRECIATION	PATIENT DAYS	863,827	14	3,880		72,223	324	12
13	35	EQUIPMENT RENT	PATIENT DAYS	863,827	14	45,937		72,223	3,841	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					\$ 833,178	\$ 496,665		\$ 69,661	25

Facility Name & ID Number **SOUTHVIEW MANOR**

# **0038943** Report Period Beginning: **01/01/2006** Ending: **2/31/2006**

**VIII. ALLOCATION OF INDIRECT COSTS**

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES  NO

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

Name of Related Organization \_\_\_\_\_  
 Street Address \_\_\_\_\_  
 City / State / Zip Code \_\_\_\_\_  
 Phone Number ( ) \_\_\_\_\_  
 Fax Number ( ) \_\_\_\_\_

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	<b>TOTALS</b>				\$	\$		\$	<b>0</b>

Facility Name & ID Number **SOUTHVIEW MANOR**

# **0038943**

Report Period Beginning:

**01/01/2006**

Ending: **2/31/2006**

**VIII. ALLOCATION OF INDIRECT COSTS**

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES  NO

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	30	DEPRECIATION S.L.	DIRECT	1	\$ 104,088	\$	1	\$ 104,088	1
2	32	INTEREST	DIRECT	1	313,711		1	313,711	2
3	32	INTEREST	DIRECT	1	179,037		1	179,037	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				\$ 596,836	\$		\$ 596,836	25

Facility Name & ID Number

SOUTHVIEW MANOR

# 0038943

Report Period Beginning:

01/01/2006

Ending:

12/31/2006

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

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

1	Name of Lender	2		3	4	5	6		7	8	9	10						
		Related**					Purpose of Loan	Monthly Payment Required					Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO											Original	Balance			
<b>A. Directly Facility Related</b>																		
<b>Long-Term</b>																		
1	ALBANY BANK		X	MORTGAGE	\$37,369.00		\$ 5,800,000	\$ 0	02/01/08	0.0600	\$ 313,711	1						
2												2						
3	SHELDON NEIDICH	X		MORTGAGE	\$22,872.00		3,550,000	0	2/01/08	0.0600	179,037	3						
4												4						
5												5						
<b>Working Capital</b>																		
6	ALBANY BANK		X	WORKING CAPITAL	INTEREST			278,000	REVOLV	PRIME +	108,264	6						
7												7						
8												8						
9	TOTAL Facility Related				\$60,241.00		\$ 9,350,000	\$ 278,000			\$ 601,012	9						
<b>B. Non-Facility Related*</b>																		
10	IRS, IDR, ETC		X	LATE FEES								10						
11												11						
12												12						
13												13						
14	TOTAL Non-Facility Related						\$ 0	\$ 0			\$ 0	14						
15	TOTALS (line 9+line14)						\$ 9,350,000	\$ 278,000			\$ 601,012	15						

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

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

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

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

**B. Real Estate Taxes**

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

1. Real Estate Tax accrual used on 2005 report.		\$	<b>208,984</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>386,365</b>	<b>2</b>
3. Under or (over) accrual (line 2 minus line 1).		\$	<b>177,381</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>35,185</b>	<b>4</b>
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>		\$		<b>5</b>
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. <b>TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>		\$		<b>6</b>
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	<b>212,566</b>	<b>7</b>

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	<b>2001</b>	<b>266,344</b>	<b>8</b>
	<b>2002</b>	<b>269,331</b>	<b>9</b>
	<b>2003</b>	<b>237,359</b>	<b>10</b>
	<b>2004</b>	<b>208,985</b>	<b>11</b>
	<b>2005</b>	<b>211,113</b>	<b>12</b>

**THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED  
2/12 OF THE 2005 BILL**

**THE PAYMENT ON LINE 2 APPLIES TO THE 2005 TAX BILL.**

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

**NOTES:**

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

**IMPORTANT NOTICE**

**TO:** Long Term Care Facilities with Real Estate Tax Rates **RE:** 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 SOUTHVIEW MANOR COUNTY COOK

FACILITY IDPH LICENSE NUMBER 0038943

CONTACT PERSON REGARDING THIS REPORT BOB KAGDA

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

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

Enter the tax index number and real estate tax assessed for 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>17-34-116-003-000</u>	<u>NURSING HOME</u>	\$ <u>73,090.39</u>	\$ <u>73,090.39</u>
2. <u>17-34-116-004-000</u>	<u>NURSING HOME</u>	\$ <u>41,545.82</u>	\$ <u>41,545.82</u>
3. <u>17-34-116-005-000</u>	<u>NURSING HOME</u>	\$ <u>31,544.03</u>	\$ <u>31,544.03</u>
4. <u>17-34-116-006-000</u>	<u>NURSING HOME</u>	\$ <u>31,544.03</u>	\$ <u>31,544.03</u>
5. <u>17-34-116-007-000</u>	<u>NURSING HOME</u>	\$ <u>31,544.03</u>	\$ <u>31,544.03</u>
6. <u>17-34-116-008-000</u>	<u>NURSING HOME</u>	\$ <u>1,844.30</u>	\$ <u>1,844.30</u>
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ <u>211,112.60</u>	\$ <u>211,112.60</u>

**B. Real Estate Tax Cost Allocations**

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

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

**C. Tax Bills**

Attach a copy of the original 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.



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

Report Period Beginning:

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

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

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	200		1993		\$ 4,059,425	\$ 104,088	39	\$ 104,088	\$	\$ 1,357,488	4
5											5
6	RELATED										6
7	PARTY				46,019						7
8	IME - office										8
	<b>Improvement Type**</b>										
9	LEASEHOLD IMPROVEMENT		1994		4,931	3,477	39	126	(3,351)	1,580	9
10	HEAT EXCHANGER		1995		4,895	3,525	39	126	(3,399)	1,496	10
11	TUB-PLUMBING		1995		11,279	8,136	39	289	(7,847)	3,432	11
12	WINDOWS		1995		613	444	39	16	(428)	185	12
13	BOILER		1995		5,239	3,849	39	134	(3,715)	1,524	13
14	DOOR REPLACEMENT		1996		4,397	3,310	39	113	(3,197)	1,200	14
15	DOOR RESTRICTORS ON ELEVATORS		1997		3,042	2,376	39	78	(2,298)	744	15
16	ALARM SYSTEM		1997		3,664	2,861	39	94	(2,767)	897	16
17	SAFETY GLASS		1997		2,099	1,638	39	54	(1,584)	515	17
18	HEATER EXHAUST STACK		1998		3,185	2,567	39	81	(2,486)	699	18
19	AIR DUCTS		1998		3,085	2,482	39	79	(2,403)	682	19
20	ACCESS PANELS		1998		2,466	2,001	39	63	(1,938)	528	20
21	HEAT EXCHANGER		1995		8,440	6,847	39	216	(6,631)	1,809	21
22	AIR DUCTS		1998		3,298	2,671	39	85	(2,586)	712	22
23	FIRE DAMPERS		1998		24,840	20,301	39	637	(19,664)	5,176	23
24	ACCESS PANELS		1998		2,724	2,225	39	70	(2,155)	569	24
25	FIRE PANELS		1998		1,264	1,029	39	33	(996)	268	25
26	BOILER		1999		4,830	4,019	39	124	(3,895)	935	26
27	FIRE DAMPERS		1999		8,280	6,893	39	212	(6,681)	1,599	27
28	ELEVATOR IMPROVEMENT		1999		5,000	4,163	39	128	(4,035)	965	28
29	FIRE DOORS		1999		5,535	4,606	39	142	(4,464)	1,071	29
30	SPRINKLER SYSTEM		1999		3,945	3,284	39	101	(3,183)	762	30
31	NEW ROOF		2000		7,000	5,587	27.5	255	(5,332)	1,668	31
32	ROOF		2003		15,390	13,969	27.5	559	(13,410)	1,980	32
33	DOOR		2003		2,300	2,087	27.5	84	(2,003)	297	33
34	WATER HEATER		2003		23,160	21,441	27.5	842	(20,599)	2,561	34
35	ELEVATOR IMPROVEMENT		2004		42,035	40,442	27.5	1,529	(38,913)	3,122	35
36	SMOKE DETECTIVE		2004		5,265	5,066	27.5	191	(4,875)	390	36

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

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

See Page 12A, Line 70 for total

**XI. OWNERSHIP COSTS (continued)**

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

1	3	4	5	6	7	8	9		
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
37	ROOF	2004	\$ 8,500	\$ 7,895	27.5	\$ 309	\$ (7,586)	\$ 914	37
38	TILING	2005	5,791	5,677	27.5	211	(5,466)	325	38
39	FIRE ALARM SYSTEM	2005	28,329	27,771	27.5	1,030	(26,741)	1,588	39
40	CARPETING	2005	1,643	1,314	5	329	(985)	493	40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 4,361,908	\$ 328,041		\$ 112,428	\$ (215,613)	\$ 1,398,174	70

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

Facility Name & ID Number SOUTHVIEW MANOR

# 0038943

Report Period Beginning:

01/01/2006

Ending:

12/31/2006

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	\$ 259,187	\$ 18,568	\$ 16,683	\$ (1,885)	10 YRS	\$ 201,873	71
72	Current Year Purchases				0			72
73	Fully Depreciated Assets				0			73
74	Related Parties	500,000	591	571	(20)			74
75	TOTALS	\$ 759,187	\$ 19,159	\$ 17,254	\$ (1,905)		\$ 201,873	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				\$	\$	\$	0		\$	76
77							0			77
78							0			78
79							0			79
80	TOTALS			\$ 0	\$ 0	\$ 0	\$ 0		\$ 0	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 5,266,790	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 347,200	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 129,682	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (217,518)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,600,047	85

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

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

G. Construction-in-Progress

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

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

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

**XII. RENTAL COSTS**

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

1. Name of Party Holding Lease: GRANITE SOUTH VIEW, LLC

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

If NO, see instructions.  YES  NO

	1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:	<u>200</u>	<u>11/01/06</u>	\$ <u>278,791</u>	<u>5.5</u>	<u>5</u>	3
4	Additions						4
5							5
6							6
7	TOTAL	<u>200</u>		\$ <u>278,791</u>			7

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

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

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

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

15. Is Movable equipment rental included in building rental?

YES  NO

16. Rental Amount for movable equipment: \$ 26,679 Description: SEE SCHEDULE ATTACHED

(Attach a schedule detailing the breakdown of movable equipment)

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

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	<u>ADMINISTRATOR</u>	<u>2005 LEXUS RX330</u>	\$ <u>689.00</u>	\$ <u>8,268</u>	17
18	<u>FACILITY</u>	<u>2004 FORD E350</u>	<u>662.50</u>	<u>8,099</u>	18
19					19
20					20
21	TOTAL		\$ <u>#####</u>	\$ <u>16,367</u>	21

10. Effective dates of current rental agreement:

Beginning 11/01/06

Ending 4/30/12

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

Fiscal Year Ending Annual Rent

12. /2007 \$ 1,672,743

13. /2008 \$ 1,686,683

14. /2009 \$ 1,756,380

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

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

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

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

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

**B. EXPENSES**

**ALLOCATION OF COSTS (d)**

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

**C. CONTRACTUAL INCOME**

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

\$

**D. NUMBER OF CNAs TRAINED**

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

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

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

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39-3	hrs	\$		\$ 152,216	\$		\$ 152,216	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			298			298	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			46,533			46,533	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescripts				86,926		86,926	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): <b>supplies, lab</b>	39-8					8,120		8,120	13
14	<b>TOTAL</b>			\$		\$ 199,047	\$ 95,046		\$ 294,093	14

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

Facility Name &amp; ID Number SOUTHVIEW MANOR

# 0038943

Report Period Beginning: 01/01/2006

Ending:

12/31/2006

## XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2006

(last day of reporting year)

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

		1	2	
		Operating	After	
			Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 21,443	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (36,880) )	1,051,173		3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	98,533		6
7	Other Prepaid Expenses	54,547		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	<b>TOTAL Current Assets</b> (sum of lines 1 thru 9)	\$ 1,225,696	\$ 0	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost			16
17	Accumulated Depreciation (book methods)			17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	429,853		21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	<b>TOTAL Long-Term Assets</b> (sum of lines 11 thru 23)	\$ 429,853	\$ 0	24
25	<b>TOTAL ASSETS</b> (sum of lines 10 and 24)	\$ 1,655,549	\$ 0	25

		1	2	
		Operating	After	
			Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 289,590	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	278,000		29
30	Accrued Salaries Payable	130,192		30
31	Accrued Taxes Payable (excluding real estate taxes)	22,166		31
32	Accrued Real Estate Taxes(Sch.IX-B)	35,185		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36				36
37				37
38	<b>TOTAL Current Liabilities</b> (sum of lines 26 thru 37)	\$ 755,133	\$ 0	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43				43
44				44
45	<b>TOTAL Long-Term Liabilities</b> (sum of lines 39 thru 44)	\$ 0	\$ 0	45
46	<b>TOTAL LIABILITIES</b> (sum of lines 38 and 45)	\$ 755,133	\$ 0	46
47	<b>TOTAL EQUITY</b> (page 18, line 24)	\$ 900,416	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY</b> (sum of lines 46 and 47)	\$ 1,655,549	\$ 0	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1 Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>			<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>0</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>416</b>	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	( )	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe) <b>MEMBERS CAPITAL</b>	<b>900,000</b>	<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ <b>900,416</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$ <b>0</b>	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>900,416</b>	<b>24</b> *

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

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

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

1

	Revenue	Amount	
	<b>A. Inpatient Care</b>		
1	Gross Revenue -- All Levels of Care	\$ 8,103,504	1
2	Discounts and Allowances for all Levels	( )	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 8,103,504	3
	<b>B. Ancillary Revenue</b>		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	108,664	6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 108,664	8
	<b>C. Other Operating Revenue</b>		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 0	23
	<b>D. Non-Operating Revenue</b>		
24	Contributions		24
25	Interest and Other Investment Income***	11	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 11	26
	<b>E. Other Revenue (specify):****</b>		
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28			28
28a	<b>PRIOR YEAR INC/EXP</b>	1,370	28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 1,370	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 8,213,549	30

2

	Expenses	Amount	
	<b>A. Operating Expenses</b>		
31	General Services	1,411,741	31
32	Health Care	2,134,868	32
33	General Administration	2,035,484	33
	<b>B. Capital Expense</b>		
34	Ownership	2,240,479	34
	<b>C. Ancillary Expense</b>		
35	Special Cost Centers	294,093	35
36	Provider Participation Fee	109,500	36
	<b>D. Other Expenses (specify):</b>		
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 8,226,165	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	(12,616)	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ (12,616)	43

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

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

TAX RETURN PREPARED ON CASH BASIS

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

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

Facility Name & ID Number **SOUTHVIEW MANOR**

# **0038943**

Report Period Beginning: **01/01/2006**

Ending:

**12/31/2006**

**XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)**

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	4,174	4,294	\$ 128,396	\$ 29.90	1
2	Assistant Director of Nursing					2
3	Registered Nurses	8,794	9,774	231,364	23.67	3
4	Licensed Practical Nurses	30,757	37,438	684,010	18.27	4
5	CNAs & Orderlies	62,254	68,424	581,561	8.50	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,783	1,962	18,710	9.54	8
9	Activity Director					9
10	Activity Assistants	9,232	10,223	102,727	10.05	10
11	Social Service Workers	9,875	10,300	154,288	14.98	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	22,003	24,073	217,418	9.03	15
16	Dishwashers					16
17	Maintenance Workers	22,394	23,758	238,982	10.06	17
18	Housekeepers	26,295	28,623	248,770	8.69	18
19	Laundry	7,013	7,855	60,978	7.76	19
20	Administrator	3,152	3,244	84,196	25.95	20
21	Assistant Administrator	3,237	3,332	62,634	18.80	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	13,881	14,199	133,525	9.40	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	2,128	2,161	30,246	14.00	31
32	Other Health Care(specify)	5,801	5,914	109,513	18.52	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	232,773	255,574	\$ 3,087,318 *	\$ 12.08	34

\* This total must agree with page 4, column 1, line 45.

\*\* See instructions.

**B. CONSULTANT SERVICES**

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference		
35	Dietary Consultant	M	\$ 8,973	1-3	35
36	Medical Director	O	2,400	9-3	36
37	Medical Records Consultant	N	0	10-3	37
38	Nurse Consultant	T	0	10-3	38
39	Pharmacist Consultant	H	2,500	10-3	39
40	Physical Therapy Consultant	L	0	10a-3	40
41	Occupational Therapy Consultant	Y	302	10a-3	41
42	Respiratory Therapy Consultant		0	10a-3	42
43	Speech Therapy Consultant	F	0	10a-3	43
44	Activity Consultant	E	0	11-3	44
45	Social Service Consultant	E	7,421	12-3	45
46	Other(specify) <b>DENTAL</b>	S	1,600	10-3	46
47	<b>PSYCHIATRIC CONSULTANT</b>		4,800	10-3	47
48					48
49	TOTAL (lines 35 - 48)		\$ 27,996		49

**C. CONTRACT NURSES**

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



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

(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009	FY2010	FY2011
1	PAINT/DECORATING	2005	\$ 13,179	3 YRS	\$	\$	\$ 2,196	\$ 4,393	\$ 4,393	\$ 2,197	\$	\$	\$
2													
3													
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19													
20	TOTALS		\$ 13,179		\$	\$	\$ 2,196	\$ 4,393	\$ 4,393	\$ 2,197	\$	\$	\$

Facility Name &amp; ID Number SOUTHVIEW MANOR

# 0038943

Report Period Beginning: 01/01/2006

Ending: 12/31/2006

**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? YES
- (2) Are there any dues to nursing home associations included on the cost report? YES  
If YES, give association name and amount. IL COUNCIL LONG TERM CARE \$11,400
- (3) Did the nursing home make political contributions or payments to a political action organization? NO If YES, have these costs been properly adjusted out of the cost report? \_\_\_\_\_
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity? \_\_\_\_\_
- (5) Have you properly capitalized all major repairs and equipment purchases? YES  
What was the average life used for new equipment added during this period? 10 YR
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 0 Line 10-2
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? YES  
If YES, give effective date of lease. 11/01/06
- (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 \_\_\_\_\_ If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.  
\_\_\_\_\_
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 109,500  
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? NO If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? YES
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? NO For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? N/A Indicate the amount. \$ \_\_\_\_\_
- (16) Travel and Transportation  
a. Are there costs included for out-of-state travel? NO  
If YES, attach a complete explanation.  
b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such a program during this reporting period. \$ \_\_\_\_\_  
c. What percent of all travel expense relates to transportation of nurses and patients? 5%  
d. Have vehicle usage logs been maintained? NO  
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? NO  
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? YES  
g. Does the facility transport residents to and from day training? NO  
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? NO  
Firm Name: \_\_\_\_\_ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? \_\_\_\_\_ If no, please explain. \_\_\_\_\_
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? YES
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? YES  
Attach invoices and a summary of services for all architect and appraisal fees