



Facility Name & ID Number Lakewood Nursing & Rehab Center

# 0046169 Report Period Beginning: 01/01/07 Ending: 12/31/07

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 04/18/2007

	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>125</u>	Skilled (SNF)	<u>131</u>	<u>47,167</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>125</u>	TOTALS	<u>131</u>	<u>47,167</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				
		2 Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	<u>14,861</u>	<u>13,064</u>	<u>11,394</u>	<u>39,319</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>14,861</u>	<u>13,064</u>	<u>11,394</u>	<u>39,319</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 83.36%

D. How many bed-hold days during this year were paid by the Department? 12 (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 02/01/2003

J. Was the facility purchased or leased after January 1, 1978?  
YES  Date 02/01/2003 NO

K. Was the facility certified for Medicare during the reporting year?  
YES  NO  If YES, enter number of beds certified 131 and days of care provided 9,283

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRAUAL  MODIFIED CASH\*  CASH\*

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

Tax Year: 12/31/07 Fiscal Year: 12/31/07

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

Facility Name & ID Number Lakewood Nursing & Rehab Center # 0046169 Report Period Beginning: 01/01/07 Ending: 12/31/07

**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 BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>A. General Services</b>										
1	Dietary	210,978	24,812	8,498	244,288		244,288	(1,685)	242,603		1
2	Food Purchase		190,883		190,883		190,883	(766)	190,117		2
3	Housekeeping	128,702	28,749		157,451		157,451	(1,931)	155,520		3
4	Laundry	46,436	18,599		65,035		65,035	(240)	64,795		4
5	Heat and Other Utilities			171,765	171,765		171,765	1,923	173,688		5
6	Maintenance	110,091		217,250	327,341		327,341	19,370	346,711		6
7	Other (specify):*							5,135	5,135		7
8	<b>TOTAL General Services</b>	<b>496,207</b>	<b>263,043</b>	<b>397,513</b>	<b>1,156,763</b>		<b>1,156,763</b>	<b>21,806</b>	<b>1,178,569</b>		<b>8</b>
	<b>B. Health Care and Programs</b>										
9	Medical Director			15,600	15,600		15,600		15,600		9
10	Nursing and Medical Records	2,512,773	151,318	3,884	2,667,975		2,667,975	7,043	2,675,018		10
10a	Therapy	161,695		86	161,781		161,781	1,756	163,537		10a
11	Activities	112,599	16,911	400	129,910		129,910		129,910		11
12	Social Services	141,267		859	142,126		142,126	5,057	147,183		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*							3,233	3,233		15
16	<b>TOTAL Health Care and Programs</b>	<b>2,928,334</b>	<b>168,229</b>	<b>20,829</b>	<b>3,117,392</b>		<b>3,117,392</b>	<b>17,089</b>	<b>3,134,481</b>		<b>16</b>
	<b>C. General Administration</b>										
17	Administrative	103,872		91,626	195,498		195,498	56,728	252,226		17
18	Directors Fees										18
19	Professional Services			355,548	355,548	(5,704)	349,844	(284,592)	65,252		19
20	Dues, Fees, Subscriptions & Promotions			51,368	51,368		51,368	(6,696)	44,672		20
21	Clerical & General Office Expenses	81,589	29,877	152,111	263,577		263,577	40,793	304,370		21
22	Employee Benefits & Payroll Taxes			571,766	571,766		571,766	(5,998)	565,768		22
23	Inservice Training & Education			3,470	3,470		3,470		3,470		23
24	Travel and Seminar			2,738	2,738		2,738	2,898	5,636		24
25	Other Admin. Staff Transportation			6,945	6,945		6,945	1,104	8,049		25
26	Insurance-Prop.Liab.Malpractice			88,344	88,344		88,344	3,100	91,444		26
27	Other (specify):*							26,958	26,958		27
28	<b>TOTAL General Administration</b>	<b>185,461</b>	<b>29,877</b>	<b>1,323,916</b>	<b>1,539,254</b>	<b>(5,704)</b>	<b>1,533,550</b>	<b>(165,705)</b>	<b>1,367,845</b>		<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	<b>3,610,002</b>	<b>461,149</b>	<b>1,742,258</b>	<b>5,813,409</b>	<b>(5,704)</b>	<b>5,807,705</b>	<b>(126,810)</b>	<b>5,680,895</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: 01/01/07 Ending: 12/31/07

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclassification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>D. Ownership</b>										
30	Depreciation			78,710	78,710		78,710	167,979	246,689		30
31	Amortization of Pre-Op. & Org.										31
32	Interest							455,931	455,931		32
33	Real Estate Taxes			65,301	65,301	5,704	71,005	1,930	72,935		33
34	Rent-Facility & Grounds			528,704	528,704		528,704	(523,723)	4,981		34
35	Rent-Equipment & Vehicles			2,718	2,718		2,718	2,430	5,148		35
36	Other (specify):*							20,787	20,787		36
37	<b>TOTAL Ownership</b>			675,433	675,433	5,704	681,137	125,334	806,471		37
	<b>Ancillary Expense</b>										
	<b>E. Special Cost Centers</b>										
38	Medically Necessary Transportation										38
39	Ancillary Service Centers		729,430	589,838	1,319,268		1,319,268	(125,035)	1,194,233		39
40	Barber and Beauty Shops			3,218	3,218		3,218		3,218		40
41	Coffee and Gift Shops										41
42	Provider Participation Fee			74,053	74,053		74,053	(3,303)	70,750		42
43	Other (specify):*							63,509	63,509		43
44	<b>TOTAL Special Cost Centers</b>		729,430	667,109	1,396,539		1,396,539	(64,829)	1,331,710		44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	3,610,002	1,190,579	3,084,800	7,885,381		7,885,381	(66,305)	7,819,076		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: 01/01/07

Ending: 12/31/07

**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	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(206)	02		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	(150,021)	30		9
10	Interest and Other Investment Income	(73,352)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(626)	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	(10,425)	21		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	(62,864)	21		24
25	Fund Raising, Advertising and Promotional	(11,634)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(12)	21		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(20,623)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (329,764)		\$	30

BHF USE ONLY						
48		49		50		51
						52

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	263,459		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ 263,459		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ (66,305)		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

SEE ACCOUNTANTS' COMPILATION REPORT

NON-ALLOWABLE EXPENSES		
Sch. V Line	Amount	Reference
1	Other Income	(5,703) 21
2	Bury Day	(38) 10
3	Patient Clothing	(218) 10
4	Theft & Damage Loss	(99) 21
5	Collection Expenses	(186) 21
6	Non-Allowable Billing Service	(2,977) 19
7	Legal Fees- Building Co.	(5,007) 19
8	Billing Fees- Building Co.	(250) 20
9	Professional Fees- Building Co.	(400) 19
10	Excess Provider Fee	(3,304) 43
11	Non-Allowable Legal Expense	(5,244) 19
12	Vending Income	(128) 2
13	Annual Report	(250) 20
14	Capitalized R&M	3,182 06
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101	Total	(20,623) 101

## STATE OF ILLINOIS

Summary A

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

# 0046169

Report Period Beginning:

01/01/07

Ending:

12/31/07

## 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			165	2,339	(4,197)			8				(1,685)	1
2	Food Purchase	(960)		203		(9)							(766)	2
3	Housekeeping			310	31	13			(2,285)				(1,931)	3
4	Laundry								(240)				(240)	4
5	Heat and Other Utilities			1,476	80	367							1,923	5
6	Maintenance	3,182		15,399	10	149		708	(78)				19,370	6
7	Other (specify):*			4,913	222								5,135	7
8	<b>TOTAL General Services</b>	<b>2,222</b>		<b>22,466</b>	<b>2,682</b>	<b>(3,677)</b>		<b>708</b>	<b>(2,595)</b>				<b>21,806</b>	<b>8</b>
	<b>B. Health Care and Programs</b>													
9	Medical Director													9
10	Nursing and Medical Records	(248)			18,168				(10,877)				7,043	10
10a	Therapy				1,756								1,756	10a
11	Activities													11
12	Social Services				5,057								5,057	12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*				3,233								3,233	15
16	<b>TOTAL Health Care and Programs</b>	<b>(248)</b>			<b>28,214</b>				<b>(10,877)</b>				<b>17,089</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative			7,047	31,914	3,007	14,760						56,728	17
18	Directors Fees													18
19	Professional Services	(13,628)	5,407	(229,393)	(47,850)	40	832						(284,592)	19
20	Fees, Subscriptions & Promotions	(12,134)	250	4,255	20	227	691		(5)				(6,696)	20
21	Clerical & General Office Expenses	(79,299)		103,625	8,261	5,040	5,060	(1,894)					40,793	21
22	Employee Benefits & Payroll Taxes			(5,976)	(22)				0				(5,998)	22
23	Inservice Training & Education													23
24	Travel and Seminar			720	383		1,795						2,898	24
25	Other Admin. Staff Transportation			932		172							1,104	25
26	Insurance-Prop.Liab.Malpractice			944	10	331	1,815						3,100	26
27	Other (specify):*			18,540	5,425	1,200	1,793						26,958	27
28	<b>TOTAL General Administration</b>	<b>(105,061)</b>	<b>5,657</b>	<b>(99,306)</b>	<b>(1,859)</b>	<b>10,017</b>	<b>26,746</b>	<b>(1,894)</b>	<b>(5)</b>				<b>(165,705)</b>	<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	<b>(103,087)</b>	<b>5,657</b>	<b>(76,840)</b>	<b>29,037</b>	<b>6,340</b>	<b>26,746</b>	<b>(1,186)</b>	<b>(13,476)</b>				<b>(126,810)</b>	<b>29</b>

## STATE OF ILLINOIS

Summary B

Facility Name & ID Number Lakewood Nursing & Rehab Center# 0046169

Report Period Beginning:

01/01/07

Ending:

12/31/07

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

	Capital Expense	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>D. Ownership</b>													
30	Depreciation	(150,021)	298,177	12,039	506	259	965	6,054					167,979	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(73,352)	493,851	22,715	2,177	431	8,988	1,121					455,931	32
33	Real Estate Taxes			1,762	119	49							1,930	33
34	Rent-Facility & Grounds		(525,965)	1,903		339							(523,723)	34
35	Rent-Equipment & Vehicles			251	4	83	2,092						2,430	35
36	Other (specify):*		20,787										20,787	36
37	<b>TOTAL Ownership</b>	<b>(223,373)</b>	<b>286,850</b>	<b>38,670</b>	<b>2,806</b>	<b>1,161</b>	<b>12,045</b>	<b>7,175</b>					<b>125,334</b>	<b>37</b>
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers					(16,440)	(86,900)	(17,775)	(3,920)				(125,035)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee	(3,303)											(3,303)	42
43	Other (specify):*						63,509						63,509	43
44	<b>TOTAL Special Cost Centers</b>	<b>(3,303)</b>				<b>(16,440)</b>	<b>(23,391)</b>	<b>(17,775)</b>	<b>(3,920)</b>				<b>(64,829)</b>	<b>44</b>
45	<b>GRAND TOTAL COST (sum of lines 29, 37 &amp; 44)</b>	<b>(329,764)</b>	<b>292,507</b>	<b>(38,170)</b>	<b>31,843</b>	<b>(8,939)</b>	<b>15,400</b>	<b>(11,786)</b>	<b>(17,396)</b>				<b>(66,305)</b>	<b>45</b>

Facility Name & ID Number Lakewood Nursing & Rehab Center

# 0046169

Report Period Beginning:

01/01/07

Ending:

12/31/07

**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	\$ 525,965	Lakewood Plainfield Property LLC	100.00%	\$	\$ (525,965)	1
2	V	32 Interest	67,215	Lakewood Plainfield Property LLC	100.00%	561,066	493,851	2
3	V	19 Legal Fees		Lakewood Plainfield Property LLC	100.00%	5,007	5,007	3
4	V	20 Filing Fees		Lakewood Plainfield Property LLC	100.00%	250	250	4
5	V	19 Professional Fees		Lakewood Plainfield Property LLC	100.00%	400	400	5
6	V	30 Depreciation		Lakewood Plainfield Property LLC	100.00%	298,177	298,177	6
7	V	36 Amortization		Lakewood Plainfield Property LLC	100.00%	20,787	20,787	7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 593,180			\$ 885,687	\$ * 292,507	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: 01/01/07Ending: 12/31/07

## 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%	\$ 165	\$ 165	15	
16	V	02	Food		Care Centers, Inc.	100.00%	203	203	16	
17	V	03	Housekeeping		Care Centers, Inc.	100.00%	310	310	17	
18	V	05	Utilities		Care Centers, Inc.	100.00%	1,476	1,476	18	
19	V	06	Maintenance		Care Centers, Inc.	100.00%	2,435	2,435	19	
20	V	17	Administrative		Care Centers, Inc.	100.00%	1,475	1,475	20	
21	V	19	Professional Fees	237,178	Care Centers, Inc.	100.00%	7,785	(229,393)	21	
22	V	20	Dues and Subscriptions		Care Centers, Inc.	100.00%	4,255	4,255	22	
23	V	21	Office and Clerical		Care Centers, Inc.	100.00%	12,333	12,333	23	
24	V	24	Seminar and Travel		Care Centers, Inc.	100.00%	720	720	24	
25	V	25	Other Staff Admin. Trans.		Care Centers, Inc.	100.00%	932	932	25	
26	V	26	Insurance		Care Centers, Inc.	100.00%	944	944	26	
27	V	30	Depreciation		Care Centers, Inc.	100.00%	12,039	12,039	27	
28	V	32	Interest		Care Centers, Inc.	100.00%	22,715	22,715	28	
29	V	33	Real Estate Taxes		Care Centers, Inc.	100.00%	1,762	1,762	29	
30	V	34	Rent - Building		Care Centers, Inc.	100.00%	1,903	1,903	30	
31	V	35	Rent - Equipment & Auto		Care Centers, Inc.	100.00%	251	251	31	
32	V	06	Maintenance	11,563	Care Centers, Inc.	100.00%	24,527	12,964	32	
33	V	07	Emp. Ben. - Gen. Serv.		Care Centers, Inc.	100.00%	4,913	4,913	33	
34	V	17	Administrative		Care Centers, Inc.	100.00%	5,572	5,572	34	
35	V	21	Office and Clerical	28,274	Care Centers, Inc.	100.00%	119,566	91,292	35	
36	V	27	Emp. Ben. - Gen. Admin.		Care Centers, Inc.	100.00%	18,540	18,540	36	
37	V	22	Employee Benefits	5,976	Care Centers, Inc.	100.00%		(5,976)	37	
38	V								38	
39	Total			\$ 282,991			\$ 244,821	\$ * (38,170)	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: 01/01/07Ending: 12/31/07

## 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	03	Housekeeping		Care Centers Clinical, Inc.	100.00%	\$ 31	\$ 31	15	
16	V	05	Utilities		Care Centers Clinical, Inc.	100.00%	80	80	16	
17	V	06	Maintenance		Care Centers Clinical, Inc.	100.00%	10	10	17	
18	V	19	Professional Fees	49,181	Care Centers Clinical, Inc.	100.00%	1,331	(47,850)	18	
19	V	20	Dues and Subscriptions		Care Centers Clinical, Inc.	100.00%	20	20	19	
20	V	21	Office & Clerical		Care Centers Clinical, Inc.	100.00%	78	78	20	
21	V	24	Travel and Seminar		Care Centers Clinical, Inc.	100.00%	383	383	21	
22	V	26	Insurance		Care Centers Clinical, Inc.	100.00%	10	10	22	
23	V	30	Depreciation		Care Centers Clinical, Inc.	100.00%	506	506	23	
24	V	32	Interest		Care Centers Clinical, Inc.	100.00%	2,177	2,177	24	
25	V	33	Real Estate Taxes		Care Centers Clinical, Inc.	100.00%	119	119	25	
26	V	35	Rent - Equipment & Auto		Care Centers Clinical, Inc.	100.00%	4	4	26	
27	V	01	Dietary Salary		Care Centers Clinical, Inc.	100.00%	2,339	2,339	27	
28	V	07	Emp. Ben. - Gen. Serv.		Care Centers Clinical, Inc.	100.00%	222	222	28	
29	V	10	Nursing Salary		Care Centers Clinical, Inc.	100.00%	18,168	18,168	29	
30	V	10a	Rehab Salary		Care Centers Clinical, Inc.	100.00%	1,756	1,756	30	
31	V	12	Social Service Salary	144	Care Centers Clinical, Inc.	100.00%	5,201	5,057	31	
32	V	15	Emp. Ben. - Healthcare		Care Centers Clinical, Inc.	100.00%	3,233	3,233	32	
33	V	17	Administration Salary		Care Centers Clinical, Inc.	100.00%	31,914	31,914	33	
34	V	21	Office Salary		Care Centers Clinical, Inc.	100.00%	8,183	8,183	34	
35	V	27	Emp. Ben. - Gen. Admin.		Care Centers Clinical, Inc.	100.00%	5,425	5,425	35	
36	V	22	Employee Benefits	22	Care Centers Clinical, Inc.	100.00%		(22)	36	
37	V								37	
38	V								38	
39	Total			\$ 49,347			\$ 81,190	\$ * 31,843	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	\$	Care Centers Health Systems, Inc.	100.00%	\$ 1,830	\$ 1,830	15
16	V	03 Housekeeping		Care Centers Health Systems, Inc.	100.00%	13	13	16
17	V	05 Heat and Other Utilities		Care Centers Health Systems, Inc.	100.00%	367	367	17
18	V	06 Maintenance		Care Centers Health Systems, Inc.	100.00%	149	149	18
19	V	19 Professional Fees		Care Centers Health Systems, Inc.	100.00%	40	40	19
20	V	20 Dues, Fees, Subscriptions		Care Centers Health Systems, Inc.	100.00%	227	227	20
21	V	21 Clerical and General Office		Care Centers Health Systems, Inc.	100.00%	786	786	21
22	V	25 Other Admin. Staff Transport.		Care Centers Health Systems, Inc.	100.00%	172	172	22
23	V	26 Insurance		Care Centers Health Systems, Inc.	100.00%	331	331	23
24	V	30 Depreciation		Care Centers Health Systems, Inc.	100.00%	259	259	24
25	V	32 Interest		Care Centers Health Systems, Inc.	100.00%	431	431	25
26	V	33 Real Estate Taxes		Care Centers Health Systems, Inc.	100.00%	49	49	26
27	V	34 Rent - Building		Care Centers Health Systems, Inc.	100.00%	339	339	27
28	V	35 Rent - Equipment		Care Centers Health Systems, Inc.	100.00%	83	83	28
29	V	01 Dietary	8,973	Care Centers Health Systems, Inc.	100.00%	2,946	(6,027)	29
30	V	02 Food	13	Care Centers Health Systems, Inc.	100.00%	4	(9)	30
31	V	03 Housekeeping		Care Centers Health Systems, Inc.	100.00%			31
32	V	10 Nursing		Care Centers Health Systems, Inc.	100.00%			32
33	V	21 Clerical and General Office		Care Centers Health Systems, Inc.	100.00%			33
34	V	25 Other Admin. Staff Transport.		Care Centers Health Systems, Inc.	100.00%			34
35	V	39 Ancillary	24,476	Care Centers Health Systems, Inc.	100.00%	8,036	(16,440)	35
36	V	17 Administrative		Care Centers Health Systems, Inc.	100.00%	3,007	3,007	36
37	V	21 Clerical and General Office		Care Centers Health Systems, Inc.	100.00%	4,254	4,254	37
38	V	27 Employee Benefits		Care Centers Health Systems, Inc.	100.00%	1,200	1,200	38
39	Total		\$ 33,462			\$ 24,523	\$ * (8,939)	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	17 Administration	\$	Therapy Works Rehabilitation Services, LLC	100.00%	\$ 1,033	\$ 1,033	15
16	V	19 Professional Fees		Therapy Works Rehabilitation Services, LLC	100.00%	832	832	16
17	V	20 Dues and Subscriptions		Therapy Works Rehabilitation Services, LLC	100.00%	691	691	17
18	V	21 Office & Clerical		Therapy Works Rehabilitation Services, LLC	100.00%	5,060	5,060	18
19	V	24 Travel and Seminar		Therapy Works Rehabilitation Services, LLC	100.00%	1,795	1,795	19
20	V	26 Insurance		Therapy Works Rehabilitation Services, LLC	100.00%	1,815	1,815	20
21	V	30 Depreciation		Therapy Works Rehabilitation Services, LLC	100.00%	965	965	21
22	V	32 Interest		Therapy Works Rehabilitation Services, LLC	100.00%	8,988	8,988	22
23	V	35 Rent - Equipment		Therapy Works Rehabilitation Services, LLC	100.00%	2,092	2,092	23
24	V	39 Ancillary		Therapy Works Rehabilitation Services, LLC	100.00%	24,238	24,238	24
25	V	17 Administrative		Therapy Works Rehabilitation Services, LLC	100.00%	13,727	13,727	25
26	V	27 Emp. Ben. - Gen. Admin.		Therapy Works Rehabilitation Services, LLC	100.00%	1,793	1,793	26
27	V	39 Ancillary	551,992	Therapy Works Rehabilitation Services, LLC	100.00%	440,854	(111,138)	27
28	V	43 Emp. Ben. - Other		Therapy Works Rehabilitation Services, LLC	100.00%	63,509	63,509	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		\$ 551,992			\$ 567,392	\$ * 15,400	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	06	Repairs	\$	Vent Lease, LLC.	100.00%	\$ 708	\$ 708	15
16	V	21	Office and Clerical		Vent Lease, LLC.	100.00%	1	1	16
17	V	30	Depreciation		Vent Lease, LLC.	100.00%	5,578	5,578	17
18	V	32	Interest		Vent Lease, LLC.	100.00%	466	466	18
19	V	30	Depreciation		Vent Lease, LLC.	100.00%	476	476	19
20	V	32	Interest		Vent Lease, LLC.	100.00%	655	655	20
21	V	21	Office and Clerical	1,895	Vent Lease, LLC.	100.00%		(1,895)	21
22	V	39	Ancillary	17,775	Vent Lease, LLC.	100.00%		(17,775)	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		\$ 19,670				\$ 7,884	\$ * (11,786)	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	1 Dietary	\$ (94)	Xcel Supply, LLC	100.00%	\$ (86)	\$ 8	15
16	V	3 Housekeeping	28,329	Xcel Supply, LLC	100.00%	26,044	(2,285)	16
17	V	4 Laundry	2,973	Xcel Supply, LLC	100.00%	2,733	(240)	17
18	V	6 Repairs & Maintenance	965	Xcel Supply, LLC	100.00%	887	(78)	18
19	V	10 Nursing	134,862	Xcel Supply, LLC	100.00%	123,985	(10,877)	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 And Subscriptions	64	Xcel Supply, LLC	100.00%	58	(5)	22
23	V	21 Office And Clerical		Xcel Supply, LLC	100.00%			23
24	V	22 Employee Benefits	5,010	Xcel Supply, LLC	100.00%	5,010	0	24
25	V	24 Seminars & Education		Xcel Supply, LLC	100.00%			25
26	V	39 Ancillary	48,603	Xcel Supply, LLC	100.00%	44,683	(3,920)	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		\$ 220,711			\$ 203,315	\$ * (17,396)	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%	\$ 132,446	\$ 132,446	15
16	V								16
17	V								17
18	V								18
19	V	22	Employee Health Insurance	132,446	CCS Employee Benefit Group	100.00%		(132,446)	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			\$ 132,446			\$ 132,446	\$ *	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: 01/01/07

Ending: 12/31/07

**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	Total			\$			\$	\$ *	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			\$			\$		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	Total			\$			\$	\$ *	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: 01/01/07 Ending: 12/31/07

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%	See Attached	0.81	1.76%	Alloc. Salary	\$	17-7	1
2	Mark Steinberg	Relative	Administrative	N/A	See Attached	1.33	2.42%	Alloc. Salary	3,268	17-7	2
3	Adam Vales	Relative	Clerical	N/A	See Attached	0.82	2.05%	Alloc. Salary	1,140	22-7	3
4	Kim Rudolph	Relative	Clerical	N/A	See Attached	0.71	2.03%	Alloc. Salary	627	22-7	4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 5,035		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: 01/01/07

Ending: 12/31/07

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: 01/01/07

Ending: 12/31/07

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 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

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	01	Dietary	Patient Days	1,625,640	33	\$ 6,823	\$ 39,312	\$ 165	1
2	02	Food	Patient Days	1,625,640	33	8,403	39,312	203	2
3	03	Housekeeping	Patient Days	1,625,640	33	12,807	39,312	310	3
4	05	Utilities	Patient Days	1,625,640	33	61,054	39,312	1,476	4
5	06	Maintenance	Patient Days	1,625,640	33	100,693	39,312	2,435	5
6	17	Administrative	Patient Days	1,625,640	33	61,000	39,312	1,475	6
7	19	Professional Fees	Patient Days	1,625,640	33	321,947	39,312	7,785	7
8	20	Dues and Subscriptions	Patient Days	1,625,640	33	175,974	39,312	4,255	8
9	21	Office and Clerical	Patient Days	1,625,640	33	509,990	39,312	12,333	9
10	24	Seminar and Travel	Patient Days	1,625,640	33	29,773	39,312	720	10
11	25	Other Staff Admin. Trans.	Patient Days	1,625,640	33	38,529	39,312	932	11
12	26	Insurance	Patient Days	1,625,640	33	39,041	39,312	944	12
13	30	Depreciation	Patient Days	1,625,640	33	497,823	39,312	12,039	13
14	32	Interest	Patient Days	1,625,640	33	939,326	39,312	22,715	14
15	33	Real Estate Taxes	Patient Days	1,625,640	33	72,865	39,312	1,762	15
16	34	Rent - Building	Patient Days	1,625,640	33	78,695	39,312	1,903	16
17	35	Rent - Equipment & Auto	Patient Days	1,625,640	33	10,366	39,312	251	17
18	06	Maintenance	Patient Days	1,625,640	33	187,019	187,019	4,523	18
19	06	Maintenance	Direct Allocation			456,812	456,812	20,004	19
20	07	Emp. Ben. - Gen. Serv.	Patient Days	1,625,640	33	91,856	39,312	4,913	20
21	17	Administrative	Patient Days	1,625,640	33	230,402	230,402	5,572	21
22	21	Office and Clerical	Patient Days	1,625,640	33	3,779,534	3,779,534	91,399	22
23	21	Office and Clerical	Direct Allocation			489,346	489,346	28,167	23
24	27	Emp. Ben. - Gen. Admin.	Patient Days	1,625,640	33	691,109	39,312	18,540	24
25	TOTALS					\$ 8,891,187	\$ 5,143,115	\$ 244,821	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lakewood Nursing & Rehab Center

# 0046169

Report Period Beginning: 01/01/07

Ending: 12/31/07

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 Care Center 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

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	03	Housekeeping	Patient Days	1,625,640	32	\$ 1,294	\$	39,312	\$ 31	1
2	05	Utilities	Patient Days	1,625,640	32	3,307		39,312	80	2
3	06	Maintenance	Patient Days	1,625,640	32	410		39,312	10	3
4	19	Professional Fees	Patient Days	1,625,640	32	55,053		39,312	1,331	4
5	20	Dues and Subscriptions	Patient Days	1,625,640	32	809		39,312	20	5
6	21	Office & Clerical	Patient Days	1,625,640	32	3,220		39,312	78	6
7	24	Travel and Seminar	Patient Days	1,625,640	32	15,843		39,312	383	7
8	26	Insurance	Patient Days	1,625,640	32	409		39,312	10	8
9	30	Depreciation	Patient Days	1,625,640	32	20,909		39,312	506	9
10	32	Interest	Patient Days	1,625,640	32	90,038		39,312	2,177	10
11	33	Real Estate Taxes	Patient Days	1,625,640	32	4,921		39,312	119	11
12	35	Rent - Equipment & Auto	Patient Days	1,625,640	32	155		39,312	4	12
13	01	Dietary Salary	Patient Days	1,625,640	32	96,717	96,717	39,312	2,339	13
14	07	Emp. Ben. - Gen. Serv.	Patient Days	1,625,640	32	9,180		39,312	222	14
15	10	Nursing Salary	Patient Days	1,625,640	32	751,308	751,308	39,312	18,168	15
16	10a	Rehab Salary	Patient Days	1,625,640	32	72,628	72,628	39,312	1,756	16
17	12	Social Service Salary	Patient Days	1,625,640	32	208,543	208,543	39,312	5,043	17
18	15	Emp. Ben. - Healthcare	Patient Days	1,625,640	32	133,126		39,312	3,219	18
19	17	Administration Salary	Patient Days	1,625,640	32	1,319,729	1,319,729	39,312	31,914	19
20	21	Office Salary	Patient Days	1,625,640	32	338,399	338,399	39,312	8,183	20
21	27	Emp. Ben. - Gen. Admin.	Patient Days	1,625,640	32	224,344		39,312	5,425	21
22	10	Nursing Salary	Direct Allocation			13,379	13,379			22
23	12	Social Service Salary	Direct Allocation			8,845	8,845		158	23
24	15	Emp. Ben. - Healthcare	Direct Allocation			1,994			14	24
25	TOTALS					\$ 3,374,561	\$ 2,809,547		\$ 81,190	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lakewood Nursing & Rehab Center

# 0046169

Report Period Beginning:

01/01/07

Ending: 12/31/07

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, 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	Gross Billable Income	4,431,674	33	94,358	85,970	1,830	1
2	03	Housekeeping	Gross Billable Income	4,431,674	33	663	85,970	13	2
3	05	Heat and Other Utilities	Gross Billable Income	4,431,674	33	18,909	85,970	367	3
4	06	Maintenance	Gross Billable Income	4,431,674	33	7,696	85,970	149	4
5	19	Professional Fees	Gross Billable Income	4,431,674	33	2,050	85,970	40	5
6	20	Dues, Fees, Subscriptions	Gross Billable Income	4,431,674	33	11,727	85,970	227	6
7	21	Clerical and General Office	Gross Billable Income	4,431,674	33	40,502	85,970	786	7
8	25	Other Admin. Staff Transport.	Gross Billable Income	4,431,674	33	8,860	85,970	172	8
9	26	Insurance	Gross Billable Income	4,431,674	33	17,050	85,970	331	9
10	30	Depreciation	Gross Billable Income	4,431,674	33	13,332	85,970	259	10
11	32	Interest	Gross Billable Income	4,431,674	33	22,225	85,970	431	11
12	33	Real Estate Taxes	Gross Billable Income	4,431,674	33	2,521	85,970	49	12
13	34	Rent - Building	Gross Billable Income	4,431,674	33	17,500	85,970	339	13
14	35	Rent - Equipment	Gross Billable Income	4,431,674	33	4,277	85,970	83	14
15	01	Dietary	Direct Billable Income	341,879	33	112,243	8,973	2,946	15
16	02	Food	Direct Billable Income	25	33	8	13	4	16
17	03	Housekeeping	Direct Billable Income	29	33	10			17
18	10	Nursing	Direct Billable Income	69,616	33	22,856			18
19	21	Clerical and General Office	Direct Billable Income	487	33	160			19
20	25	Other Admin. Staff Transport.	Direct Billable Income	1,200	33	394			20
21	39	Ancillary	Direct Billable Income	4,018,438	33	1,319,298	24,476	8,036	21
22	17	Administrative	Gross Billable Income	4,431,674	33	155,031	155,031	3,007	22
23	21	Clerical and General Office	Gross Billable Income	4,431,674	33	219,270	219,270	4,254	23
24	27	Employee Benefits	Gross Billable Income	4,431,674	33	61,873	85,970	1,200	24
25	TOTALS					\$ 2,152,809	\$ 374,301	\$ 24,523	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lakewood Nursing & Rehab Center

# 0046169

Report Period Beginning: 01/01/07

Ending: 12/31/07

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 Rehabilitation 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	17	Administration	Billable Income	4,671,432	16	\$ 9,000	\$ 536,136	\$ 1,033	1	
2	19	Professional Fees	Billable Income	4,671,432	16	7,245	536,136	832	2	
3	20	Dues and Subscriptions	Billable Income	4,671,432	16	6,024	536,136	691	3	
4	21	Office & Clerical	Billable Income	4,671,432	16	44,084	536,136	5,060	4	
5	24	Travel and Seminar	Billable Income	4,671,432	16	15,640	536,136	1,795	5	
6	26	Insurance	Billable Income	4,671,432	16	15,816	536,136	1,815	6	
7	30	Depreciation	Billable Income	4,671,432	16	8,410	536,136	965	7	
8	32	Interest	Billable Income	4,671,432	16	78,317	536,136	8,988	8	
9	35	Rent - Equipment	Billable Income	4,671,432	16	18,231	536,136	2,092	9	
10	39	Ancillary	Billable Income	4,671,432	16	211,187	536,136	24,238	10	
11	17	Administrative	Billable Income	4,671,432	16	119,603	119,603	536,136	13,727	11
12	27	Emp. Ben. - Gen. Admin.	Billable Income	4,671,432	16	15,625	536,136	1,793	12	
13	39	Ancillary	Billable Income	4,671,432	16	3,841,227	3,841,227	536,136	440,854	13
14	43	Emp. Ben. - Other	Billable Income	4,671,432	16	553,364	536,136	63,509	14	
15									15	
16									16	
17									17	
18									18	
19									19	
20									20	
21									21	
22									22	
23									23	
24									24	
25	TOTALS					\$ 4,943,774	\$ 3,960,830	\$ 567,392	25	

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lakewood Nursing & Rehab Center

# 0046169

Report Period Beginning: 01/01/07

Ending: 12/31/07

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	892,186	27	\$ 35,557	\$ 17,775	\$ 708	1
2	21	Office and Clerical	Direct Billing	892,186	27	44	17,775	1	2
3	30	Depreciation	Direct Billing	892,186	27	280,000	17,775	5,578	3
4	32	Interest	Direct Billing	892,186	27	23,404	17,775	466	4
5	30	Depreciation	Patient Days	1,625,640	33	19,677	39,312	476	5
6	32	Interest	Patient Days	1,625,640	33	27,081	39,312	655	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					\$ 385,762	\$	\$ 7,884	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lakewood Nursing & Rehab Center

# 0046169

Report Period Beginning: 01/01/07

Ending: 12/31/07

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	1	Dietary						(86)	1
2	3	Housekeeping						26,044	2
3	4	Laundry						2,733	3
4	6	Repairs & Maintenance						887	4
5	10	Nursing						123,985	5
6	11	Activities							6
7	12	Social Service							7
8	20	Dues, Fees And Subscriptions						58	8
9	21	Office And Clerical							9
10	22	Employee Benefits						5,010	10
11	24	Seminars & Education							11
12	39	Ancillary						44,683	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							203,315	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lakewood Nursing & Rehab Center

# 0046169

Report Period Beginning: 01/01/07

Ending: 12/31/07

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 W. 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		\$	\$		\$ 132,446	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				\$	\$		\$ 132,446	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lakewood Nursing & Rehab Center

# 0046169

Report Period Beginning: 01/01/07

Ending: 12/31/07

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lakewood Nursing & Rehab Center

# 0046169

Report Period Beginning: 01/01/07

Ending: 12/31/07

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

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	La Salle Bank		X	Construction Loan			\$	748,501		\$	91,240	1								
2	Business Partners		X	Mortgage				5,002,039			322,398	2								
3	Rothner Health Ventures		X								53,351	3								
4	Hunter Management		X								96,125	4								
5	See Supplemental Schedule										(2,048)	5								
<b>Working Capital</b>																				
6												6								
7												7								
8	See Supplemental Schedule											8								
9	<b>TOTAL Facility Related</b>						\$	5,750,540		\$	561,066	9								
<b>B. Non-Facility Related*</b>																				
10	Interest Income										(73,352)	10								
11	Interest Income (Building Co.)										(67,215)	11								
12												12								
13	See Supplemental Schedule										35,432	13								
14	<b>TOTAL Non-Facility Related</b>						\$			\$	(105,135)	14								
15	<b>TOTALS (line 9+line14)</b>						\$	5,750,540		\$	455,931	15								

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

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

\*\* 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: 01/01/07 Ending: 12/31/07

**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 Name of Lender	2 Related**		3 Purpose of Loan	4 Monthly Payment Required	5 Date of Note	6 Amount of Note		8 Maturity Date	9 Interest Rate (4 Digits)	10 Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	<b>A. Directly Facility Related</b>											
	<b>Long-Term</b>											
1	A.N.R. Inc		X				\$	\$			\$ (2,403)	1
2	Cole Taylor		X								355	2
3												3
4												4
5												5
6												6
7	TOTAL Long-Term										(2,048)	7
	<b>Working Capital</b>											
8							\$	\$			\$	8
9												9
10												10
11												11
12												12
13												13
14	TOTAL Working Capital											14
	<b>B. Non-Facility Related*</b>											
15	Care Centers, Inc.		X				\$	\$			\$ 22,715	15
16	Care Centers Clinical		X								2,177	16
17	Care Centers Health Systems Inc.		X								431	17
18	Therapy Works Rehab Services		X								8,988	18
19	Vent Lease, LLC		X								1,121	19
20	TOTAL Non-Facility Related										35,432	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 2006 report.		\$ 62,500	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		\$ 64,272	2
3. Under or (over) accrual (line 2 minus line 1).		\$ 1,772	3
4. Real Estate Tax accrual used for 2007 report. (Detail and explain your calculation of this accrual on the lines below.)		\$ 65,459	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>		\$ 5,704	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. <b>TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>		\$ _____	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$ 72,935	7
Real Estate Tax History:			
Real Estate Tax Bill for Calendar Year:	2002	45,196	8
	2003	43,903	9
	2004	46,430	10
	2005	59,502	11
	2006	62,342	12
<u>2007 Accrual = \$62,342 x 1.05 = \$65,459</u>			
<u>Care Centers Allocation = \$1,762</u>			
<u>CC Clinical Allocation = \$119</u>			
<u>CC Health Systems Allocation = \$49</u>			
	<b>FOR BHF USE ONLY</b>		
13	FROM R. E. TAX STATEMENT FOR 2006	\$	13
14	PLUS APPEAL COST FROM LINE 5	\$	14
15	LESS REFUND FROM LINE 6	\$	15
16	AMOUNT TO USE FOR RATE CALCULATION	\$	16

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:** 2006 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 2006 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2006.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2006 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 2007 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.

**2006 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 2006 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 2006.

(A)	(B)	(C)	(D) Tax Applicable to Nursing Home
Tax Index Number	Property Description	Total Tax	
1. 06-03-10-312-003-0000	Long Term Care Property	\$ 62,342.02	\$ 62,342.02
2. See Attached	Care Centers, Inc.	\$ 46,662.50	\$ 1,128.41
3. See Attached	Care Centers Health Systems, LLC	\$ 2,476.87	\$ 48.05
4. See Attached	Care Centers Clinical, Inc.	\$ 4,834.42	\$ 116.91
5. See Attached	Care Centers Building, LLC.	\$ 24,152.48	\$ 584.07
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ <u>140,468.29</u>	\$ <u>64,219.46</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 2006 tax bills which were listed in Section A to this statement. Be sure to use the 2006 tax bill which is normally paid during 2007.

**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:

01/01/07 Ending:

12/31/07

**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>	<u>1</u>
2	<u>Care Centers Allocation</u>			<u>9,989</u>	<u>2</u>
3	<b>TOTALS</b>	<u>273,121</u>		<u>\$ 247,368</u>	<u>3</u>

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lakewood Nursing & Rehab Center

# 0046169

Report Period Beginning:

01/01/07

Ending:

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**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	Various			2003	11,804		20	1,095	1,095	4,872	9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
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31											31
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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:

01/01/07

Ending:

12/31/07

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
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60								60
61								61
62								62
63								63
64								64
65								65
66								66
67		4,145,053	298,178		141,376	(156,802)	614,290	67
68		55,585	2,942		2,942		18,313	68
69			78,710			(78,710)		69
70		\$ 4,212,442	\$ 379,830		\$ 145,413	\$ (234,417)	\$ 637,475	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:

01/01/07

Ending:

12/31/07

**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>		\$ 4,212,442	\$ 379,830		\$ 145,413	\$ (234,417)	\$ 637,475	1
2	Water Heater	2004	3,295		20	275	275	1,075	2
3	Hot Water System	2004	1,270		20	64	64	212	3
4	Water Heater	2004	908		20	45	45	151	4
5	Smoke Dampers	2004	1,082		20	54	54	180	5
6	Compressor	2004	5,987		20	299	299	998	6
7	Generator	2004	1,181		20	169	169	563	7
8	Wall Heater	2004	818		20	68	68	216	8
9	Engineering Fees	2004	2,350		20	118	118	372	9
10	Nurse Call System - Call Cords	2004	607		20	30	30	121	10
11	Alarm - Transmitter	2004	516		20	26	26	97	11
12	Alarm - Controller / Receiver	2004	1,215		20	61	61	228	12
13	Overbed Lights	2004	656		20	33	33	120	13
14	Alarm Repairs	2004	557		20	28	28	102	14
15	Cubicle Curtains	2004	1,738		20	87	87	319	15
16	Roof Work	2004	1,665		20	83	83	298	16
17	Alarms	2004	763		20	38	38	137	17
18	New Locks	2004	729		20	36	36	118	18
19	Wall Unit - Circuit Board	2004	838		20	42	42	133	19
20	Electrical Relocation	2004	15,497		20	775	775	2,518	20
21	Dining Room Renovations	2005	3,000		20	150	150	438	21
22	Spinkler Heads	2005	6,000		20	857	857	1,929	22
23	Roof Repair	2005	1,750		20	88	88	233	23
24	Blinds	2005	1,885		20	94	94	204	24
25	Sprinkler	2005	1,957		20	98	98	204	25
26	Preferred Mechanical - Update Lobby/Office Ac System	2006	7,200		20	600	600	900	26
27	Noble Blacktop Serv. - Work On Parking Lot & Ramp	2006	8,825		20	883	883	1,250	27
28	Rf Technologies - Code Alert/Model 70	2006	10,393		20	2,079	2,079	2,598	28
29	Alarm System	2006	8,817		20	1,260	1,260	1,784	29
30	Hth Telecommunications - New Phone & Lines In New Wing	2006	27,279		20	2,728	2,728	4,547	30
31	R&R Septic & Sewer Svc 06-5404	2006	3,750		20	750	750	813	31
32	Legat Architect - Additions & Alterations; Kitchen Redesign	2006	50,929		20	2,546	2,546	4,031	32
33	2900 2 Uniduct Latching Raceway"	2007	6,013		20	301	301	301	33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 4,391,912	\$ 379,830		\$ 160,178	\$ (219,652)	\$ 664,665	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:

01/01/07

Ending:

12/31/07

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	<b>Totals from Page 12B, Carried Forward</b>		\$ 4,391,912	\$ 379,830		\$ 160,178	\$ (219,652)	\$ 664,665	1
2	Blinds For 3 Rooms	2007	2,746		20	229	229	229	2
3	Windows	2007	6,000		20	800	800	800	3
4	Painting (Transfer Expense From Home Office)	2007	9,174		20	4,587	4,587	4,587	4
5	Install 1 New Twin 100A Switch	2007	3,500		20	29	29	29	5
6	5 X \$1986.88 Gazebo	2007	9,934		20	290	290	290	6
7	Healthcare Security System	2007	3,182		20	159	159	159	7
8									8
9									9
10									10
11									11
12									12
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31									31
32									32
33									33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 4,426,448	\$ 379,830		\$ 166,273	\$ (213,557)	\$ 670,759	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:

01/01/07

Ending:

12/31/07

**XI. OWNERSHIP COSTS (continued)**

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	<b>Totals from Page 12C, Carried Forward</b>		\$ 4,426,448	\$ 379,830		\$ 166,273	\$ (213,557)	\$ 670,759	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
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31									31
32									32
33									33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 4,426,448	\$ 379,830		\$ 166,273	\$ (213,557)	\$ 670,759	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:

01/01/07

Ending:

12/31/07

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		\$ 4,426,448	\$ 379,830		\$ 166,273	\$ (213,557)	\$ 670,759	1
2									2
3									3
4									4
5									5
6									6
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29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 4,426,448	\$ 379,830		\$ 166,273	\$ (213,557)	\$ 670,759	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:

01/01/07

Ending:

12/31/07

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12E, Carried Forward		\$ 4,426,448	\$ 379,830		\$ 166,273	\$ (213,557)	\$ 670,759	1
2									2
3									3
4									4
5									5
6									6
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30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 4,426,448	\$ 379,830		\$ 166,273	\$ (213,557)	\$ 670,759	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:

01/01/07

Ending:

12/31/07

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		\$ 4,426,448	\$ 379,830		\$ 166,273	\$ (213,557)	\$ 670,759	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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30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 4,426,448	\$ 379,830		\$ 166,273	\$ (213,557)	\$ 670,759	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:

01/01/07

Ending:

12/31/07

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12G, Carried Forward		\$ 4,426,448	\$ 379,830		\$ 166,273	\$ (213,557)	\$ 670,759	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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28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 4,426,448	\$ 379,830		\$ 166,273	\$ (213,557)	\$ 670,759	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:

01/01/07

Ending:

12/31/07

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		\$ 4,426,448	\$ 379,830		\$ 166,273	\$ (213,557)	\$ 670,759	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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32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 4,426,448	\$ 379,830		\$ 166,273	\$ (213,557)	\$ 670,759	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:

01/01/07

Ending:

12/31/07

**XI. OWNERSHIP COSTS (continued)**

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12I, Carried Forward		\$ 4,426,448	\$ 379,830		\$ 166,273	\$ (213,557)	\$ 670,759	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
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32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 4,426,448	\$ 379,830		\$ 166,273	\$ (213,557)	\$ 670,759	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:

01/01/07

Ending:

12/31/07

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12J, Carried Forward		\$ 4,426,448	\$ 379,830		\$ 166,273	\$ (213,557)	\$ 670,759	1
2									2
3									3
4									4
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31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 4,426,448	\$ 379,830		\$ 166,273	\$ (213,557)	\$ 670,759	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:

01/01/07

Ending:

12/31/07

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12K, Carried Forward		\$ 4,426,448	\$ 379,830		\$ 166,273	\$ (213,557)	\$ 670,759	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)		\$ 4,426,448	\$ 379,830		\$ 166,273	\$ (213,557)	\$ 670,759	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:

01/01/07

Ending:

12/31/07

**XI. OWNERSHIP COSTS (continued)**

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	<b>Totals from Page 12L, Carried Forward</b>		\$ 4,426,448	\$ 379,830		\$ 166,273	\$ (213,557)	\$ 670,759	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	<b>TOTAL (lines 1 thru 33)</b>		\$ 4,426,448	\$ 379,830		\$ 166,273	\$ (213,557)	\$ 670,759	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:

01/01/07

Ending:

12/31/07

**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 12M, Carried Forward</b>	\$ 4,426,448	\$ 379,830		\$ 166,273	\$ (213,557)	\$ 670,759	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	<b>TOTAL (lines 1 thru 33)</b>	\$ 4,426,448	\$ 379,830		\$ 166,273	\$ (213,557)	\$ 670,759	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:

01/01/07

Ending:

12/31/07

**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 12N, Carried Forward</b>		\$ 4,426,448	\$ 379,830		\$ 166,273	\$ (213,557)	\$ 670,759	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	<b>TOTAL (lines 1 thru 33)</b>		\$ 4,426,448	\$ 379,830		\$ 166,273	\$ (213,557)	\$ 670,759	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:

01/01/07

Ending:

12/31/07

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12O, Carried Forward		\$ 4,426,448	\$ 379,830		\$ 166,273	\$ (213,557)	\$ 670,759	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)		\$ 4,426,448	\$ 379,830		\$ 166,273	\$ (213,557)	\$ 670,759	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:

01/01/07

Ending:

12/31/07

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12P, Carried Forward		\$ 4,426,448	\$ 379,830		\$ 166,273	\$ (213,557)	\$ 670,759	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)		\$ 4,426,448	\$ 379,830		\$ 166,273	\$ (213,557)	\$ 670,759	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:

01/01/07

Ending:

12/31/07

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	131		2003	1971	\$ 2,099,630	\$	39	\$ 49,105	\$ 49,105	\$ 245,531	4
5											5
6											6
7											7
8											8
	<b>Improvement Type**</b>										
9	Lakewood Plainfield Property		2003	2003	691,221		20	24,561	24,561	162,805	9
10	Construction Project		2005	2005	1,354,202		20	67,710	67,710	205,954	10
11											11
12											12
13											13
14	Depreciation					298,178			(298,178)		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:

01/01/07

Ending:

12/31/07

**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>	\$	4,145,053	\$	298,178	\$	141,376	\$	(156,802)	\$	614,290	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:

01/01/07

Ending:

12/31/07

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	\$ 10,769	\$ 276		\$ 276	\$	\$ 1,461	4
5		Care Centers Clinical Allocation	2002	2002	1,116	29		29		151	5
6		Care Centers Health Systems Allocation	2002	2002	459	12		12		62	6
7		Hillside (Storage and Training)	1996	1996	18,260	468		468		5,170	7
8											8
		Improvement Type**									
9		2201 Main LLC Allocation		2002	8,896	813	20	813		4,073	9
10		2201 Main LLC Allocation		2003	10,483	958	20	958		4,799	10
11		2201 Main LLC Allocation		2005	521	55	20	55		132	11
12											12
13		Care Centers Clinical Allocation		2002	922	84	20	84		422	13
14		Care Centers Clinical Allocation		2003	1,086	99	20	99		497	14
15		Care Centers Clinical Allocation		2005	54	6	20	6		14	15
16											16
17		Care Centers Health Systems Allocation		2002	379	35	20	35		173	17
18		Care Centers Health Systems Allocation		2003	446	41	20	41		204	18
19		Care Centers Health Systems Allocation		2005	22	2	20	2		6	19
20											20
21		Care Centers Inc.		2007	111	7	20	7		7	21
22											22
23		Hillside (Storage and Training)		1996	308	-	20	-		308	23
24		Hillside (Storage and Training)		1997	1,753	57	20	57		834	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:

01/01/07

Ending:

12/31/07

**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>	\$	\$ 55,585		\$ 2,942	\$	\$ 18,313	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: 01/01/07 Ending: 12/31/07

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	\$ 420,463	\$ 15,327	\$ 59,282	\$ 43,955	10	\$ 215,574	71
72	Current Year Purchases	134,575	109	19,690	19,581	10	19,690	72
73	Fully Depreciated Assets	17,107				10	17,107	73
74								74
75	TOTALS	\$ 572,145	\$ 15,436	\$ 78,972	\$ 63,536		\$ 252,371	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 Clinical	Allocation	2007	\$ 1,738	\$ 257	\$ 257		5	\$ 328	76
77	Care Centers, Inc.	Allocation	2007	20,316	1,179	1,179		5	16,688	77
78	Care Centers Health Sys.	Allocation	2007	245	8	8		5	8	78
79										79
80	TOTALS			\$ 22,299	\$ 1,444	\$ 1,444			\$ 17,024	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)	\$ 5,268,260	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 396,710	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 246,689	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (150,021)	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 940,154	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				2,739			5
6	Care Centers Allocation				2,242			6
7	TOTAL				\$ 4,981			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.	_____ /2008	\$ _____
13.	_____ /2009	\$ _____
14.	_____ /2010	\$ _____

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: \$ 5,148 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	<b>TOTALS</b>	\$	\$	\$	\$
10	<b>SUM OF line 9, col. 1 and 2 (e)</b>	\$			

**C. CONTRACTUAL INCOME**

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

\$

**D. NUMBER OF CNAs TRAINED**

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

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

- (e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
  - (f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.
- 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	\$		\$ 216,096	\$		\$ 216,096	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			73,532			73,532	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			262,366			262,366	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				527,701		527,701	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>See Supplemental</b>					37,844	201,729		239,573	13
14	<b>TOTAL</b>			\$		\$ 589,838	\$ 729,430		\$ 1,319,268	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: 01/01/07

Ending:

12/31/07

## XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/07

(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	\$ 47,991	\$ 75,024	1
2	Cash-Patient Deposits	21,112	21,112	2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance )	651,967	657,352	3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	17,692	17,692	6
7	Other Prepaid Expenses	530	530	7
8	Accounts Receivable (owners or related parties)	1,533,537	(1,402,140)	8
9	Other(specify): <a href="#">See Attached Schedule</a>	20,525	20,525	9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 2,293,354	\$ (609,905)	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		9,109,487	14
15	Leasehold Improvements, at Historical Cost	98,070	98,070	15
16	Equipment, at Historical Cost	437,799	437,799	16
17	Accumulated Depreciation (book methods)	(158,199)	(1,312,524)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs		258,634	19
20	Accumulated Amortization - Organization & Pre-Operating Costs		(61,829)	20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <a href="#">See Attached Schedule</a>			23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 377,670	\$ 8,767,016	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 2,671,024	\$ 8,157,111	25

		1 Operating	2 After Consolidation*	
<b>C. Current Liabilities</b>				
26	Accounts Payable	\$ 360,536	\$ 360,536	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	17,025	17,025	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	247,928	247,928	30
31	Accrued Taxes Payable (excluding real estate taxes)	13,197	13,197	31
32	Accrued Real Estate Taxes(Sch.IX-B)	65,459	65,459	32
33	Accrued Interest Payable		320,783	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>	406,908	406,908	36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 1,111,053	\$ 1,431,836	38
<b>D. Long-Term Liabilities</b>				
39	Long-Term Notes Payable			39
40	Mortgage Payable		5,750,540	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>	\$	\$ 5,750,540	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 1,111,053	\$ 7,182,376	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 1,559,971	\$ 974,735	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 2,671,024	\$ 8,157,111	48

SEE ACCOUNTANTS' COMPILATION REPORT

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,569,009	1
2	Restatements (describe):		2
3	Medicare Settlements	(607)	3
4	Depreciation	2,971	4
5	Rounding	(8)	5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,571,365	6
<b>A. Additions (deductions):</b>			
7	NET Income (Loss) (from page 19, line 43)	217,304	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	(228,698)	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)	\$ (11,394)	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)	\$ 1,559,971	24 *

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lakewood Nursing & Rehab Center# 0046169Report Period Beginning: 01/01/07Ending: 12/31/07**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	\$ 7,930,750	1
2	Discounts and Allowances for all Levels	(2,601,238)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 5,329,512	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,961,313	6
7	Oxygen	1,517	7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 1,962,830	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	1,926	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	528,809	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	126,985	19
20	Radiology and X-Ray	20,120	20
21	Other Medical Services	52,442	21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 730,282	23
<b>D. Non-Operating Revenue</b>			
24	Contributions	848	24
25	Interest and Other Investment Income***	73,352	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 74,200	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<u>See Supplemental Schedule</u>	5,861	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 5,861	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 8,102,685	30

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	1,156,763	31
32	Health Care	3,117,392	32
33	General Administration	1,539,254	33
<b>B. Capital Expense</b>			
34	Ownership	675,433	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	1,322,486	35
36	Provider Participation Fee	74,053	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 7,885,381	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	217,304	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 217,304	43

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

\*\* Does this agree with taxable income (loss) per Federal Income Tax Return? Not Completed 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:

01/01/07

Ending:

12/31/07

**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	1,862	2,136	\$ 75,225	\$ 35.22	1
2	Assistant Director of Nursing	1,336	1,471	44,543	30.28	2
3	Registered Nurses	27,720	30,544	863,720	28.28	3
4	Licensed Practical Nurses	17,950	20,302	496,531	24.46	4
5	CNAs & Orderlies	76,704	84,675	983,941	11.62	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	8,512	9,585	161,695	16.87	8
9	Activity Director	1,795	2,109	46,215	21.91	9
10	Activity Assistants	7,452	7,838	66,384	8.47	10
11	Social Service Workers	7,353	7,895	141,267	17.89	11
12	Dietician					12
13	Food Service Supervisor	1,890	2,068	40,671	19.67	13
14	Head Cook					14
15	Cook Helpers/Assistants	5,830	6,203	82,204	13.25	15
16	Dishwashers	9,516	10,340	88,103	8.52	16
17	Maintenance Workers	6,153	6,725	110,091	16.37	17
18	Housekeepers	13,488	14,903	128,702	8.64	18
19	Laundry	4,993	5,384	46,436	8.62	19
20	Administrator	1,954	2,217	89,055	40.17	20
21	Assistant Administrator	722	774	14,817	19.14	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	6,518	7,053	81,589	11.57	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	2,668	2,900	48,813	16.83	31
32	Other Health Care(specify)					32
33	Other(specify) <u>See Supplemental</u>					33
34	TOTAL (lines 1 - 33)	204,416	225,122	\$ 3,610,002 *	\$ 16.04	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	195	\$ 8,498	01-03	35
36	Medical Director	Monthly	15,600	09-03	36
37	Medical Records Consultant	Monthly	514	10-03	37
38	Nurse Consultant	Monthly	100	10-03	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	400	11-03	44
45	Social Service Consultant	Monthly	859	12-03	45
46	Other(specify) <u>Psychologist</u>		50	10a-03	46
47	<u>Hospice Coordinator</u>	Monthly	1,875	10-03	47
48	<u>Therapy Consultant</u>	See Attached	36	10a-03	48
49	TOTAL (lines 35 - 48)	203	\$ 29,327		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



**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								
					FY2004	FY2005	FY2006	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012
1	N/A		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

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? Yes If YES, what is the capacity? 131
- (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. \$ 46,231 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. \$ 70,750  
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? \_\_\_\_\_ 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: N/A The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? N/A If no, please explain. N/A
- (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 \$5,000, 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