

		FOR BHF USE					

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2008
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2008)

IMPORTANT NOTICE
 THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

<p>I. IDPH License ID Number: <u>0047779</u></p> <p>Facility Name: <u>LAKEFRONT NURSING & REHAB CTR</u></p> <p>Address: <u>7618 NORTH SHERIDAN ROAD</u> <u>CHICAGO</u> <u>60626</u> Number City Zip Code</p> <p>County: <u>COOK</u></p> <p>Telephone Number: <u>(773) 743-7711</u> Fax # <u>(773) 761-3387</u></p> <p>HFS ID Number: <u>20 4004714-001</u></p> <p>Date of Initial License for Current Owners: <u>04/1/06</u></p> <p>Type of Ownership:</p> <table border="0"> <tr> <td><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input checked="" type="checkbox"/> PROPRIETARY</td> <td><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td>IRS Exemption Code _____</td> <td><input type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> "Sub-S" Corp.</td> <td></td> </tr> <tr> <td></td> <td><input checked="" type="checkbox"/> Limited Liability Co.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other _____</td> <td></td> </tr> </table> <p>In the event there are further questions about this report, please contact: Name: <u>BOB KAGDA</u> Telephone Number: <u>(847) 675-3585</u> Email Address: _____</p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County	IRS Exemption Code _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input type="checkbox"/> "Sub-S" Corp.			<input checked="" type="checkbox"/> Limited Liability Co.			<input type="checkbox"/> Trust			<input type="checkbox"/> Other _____		<p>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/2008</u> to <u>12/31/2008</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="1"> <tr> <td rowspan="3" style="width: 20%; vertical-align: top;">Officer or Administrator of Provider</td> <td>(Signed) _____</td> </tr> <tr> <td>(Type or Print Name) <u>MENACHEM SHABAT</u></td> </tr> <tr> <td>(Title) <u>MEMBER</u></td> </tr> <tr> <td rowspan="4" style="width: 20%; vertical-align: top;">Paid Preparer</td> <td>(Signed) <u>(SEE ATTACHED ACCOUNTANTS' REPORT)</u></td> </tr> <tr> <td>(Date) _____</td> </tr> <tr> <td>(Print Name and Title) <u>BOB KAGDA</u> <u>VICE PRESIDENT</u></td> </tr> <tr> <td>(Firm Name & Address) <u>KRUPNICK, BOKOR, KAGDA & BROOKS, LTD</u> <u>3750 W DEVON, LINCOLNWOOD, IL 60712-1124</u></td> </tr> <tr> <td colspan="2">(Telephone) <u>(847) 675-3585</u> Fax # <u>(847) 675-5777</u></td> </tr> <tr> <td colspan="2">MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630</td> </tr> </table>	Officer or Administrator of Provider	(Signed) _____	(Type or Print Name) <u>MENACHEM SHABAT</u>	(Title) <u>MEMBER</u>	Paid Preparer	(Signed) <u>(SEE ATTACHED ACCOUNTANTS' REPORT)</u>	(Date) _____	(Print Name and Title) <u>BOB KAGDA</u> <u>VICE PRESIDENT</u>	(Firm Name & Address) <u>KRUPNICK, BOKOR, KAGDA & BROOKS, LTD</u> <u>3750 W DEVON, LINCOLNWOOD, IL 60712-1124</u>	(Telephone) <u>(847) 675-3585</u> Fax # <u>(847) 675-5777</u>		MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630	
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Facility Name & ID Number LAKEFRONT NURSING & REHAB CTR

0047779 Report Period Beginning: 01/01/2008 Ending: 12/31/2008

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	99	Skilled (SNF)	99	36,234	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	99	TOTALS	99	36,234	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	2,012	45	3,798	5,855	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD	26,341	382	1,073	27,796	11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	28,353	427	4,871	33,651	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 92.87%

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

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

NONE

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

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

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

I. On what date did you start providing long term care at this location?
Date started 04/01/06

J. Was the facility purchased or leased after January 1, 1978?
YES Date 04/01/06 NO

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 99 and days of care provided 3,798

Medicare Intermediary administar federal

IV. ACCOUNTING BASIS

ACCRAUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/2008 Fiscal Year: 12/31/2008

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

Facility Name & ID Number LAKEFRONT NURSING & REHAB CTR # 0047779 Report Period Beginning: 01/01/2008 Ending: 12/31/2008

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
	A. General Services										
1	Dietary	188,733	28,044		216,777		216,777		216,777		1
2	Food Purchase		164,492		164,492	(22,893)	141,599	(1,394)	140,205		2
3	Housekeeping	95,611	22,415		118,026		118,026		118,026		3
4	Laundry	32,787	6,190		38,977		38,977		38,977		4
5	Heat and Other Utilities			106,805	106,805		106,805		106,805		5
6	Maintenance	78,025	10,419	27,213	115,657		115,657		115,657		6
7	Other (specify):*			10,419	10,419		10,419		10,419		7
8	TOTAL General Services	395,156	231,560	144,437	771,153	(22,893)	748,260	(1,394)	746,866		8
	B. Health Care and Programs										
9	Medical Director			21,000	21,000		21,000		21,000		9
10	Nursing and Medical Records	1,173,998	61,744	82,346	1,318,088		1,318,088		1,318,088		10
10a	Therapy	132,465	337		132,802		132,802		132,802		10a
11	Activities	44,801	10,775	2,522	58,098		58,098		58,098		11
12	Social Services	46,391		3,310	49,701		49,701		49,701		12
13	CNA Training										13
14	Program Transportation			546	546		546		546		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,397,655	72,856	109,724	1,580,235		1,580,235		1,580,235		16
	C. General Administration										
17	Administrative	154,035		229,265	383,300		383,300	62,360	445,660		17
18	Directors Fees										18
19	Professional Services			50,558	50,558		50,558	5,776	56,334		19
20	Dues, Fees, Subscriptions & Promotions			33,734	33,734		33,734	(20,242)	13,492		20
21	Clerical & General Office Expenses	52,527	33,326	45,992	131,845		131,845	24,501	156,346		21
22	Employee Benefits & Payroll Taxes			316,479	316,479	22,893	339,372		339,372		22
23	Inservice Training & Education										23
24	Travel and Seminar			302	302		302		302		24
25	Other Admin. Staff Transportation			4,668	4,668		4,668	(4,668)			25
26	Insurance-Prop.Liab.Malpractice			117,516	117,516		117,516		117,516		26
27	Other (specify):*			59,742	59,742		59,742	(53,140)	6,602		27
28	TOTAL General Administration	206,562	33,326	858,256	1,098,144	22,893	1,121,037	14,587	1,135,624		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,999,373	337,742	1,112,417	3,449,532		3,449,532	13,193	3,462,725		29

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

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

V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE	SCHED REF	TOTAL
1	DIETARY	
	DIETITIAN CONSULTANT XVIII B 35-2	0
	REPAIRS & MAINTENANCE	0
		0
3	HOUSEKEEPING	
		0
		0
4	LAUNDRY	
	EQUIPMENT REPAIRS & MAINTENANCE	0
		0
5	HEAT & OTHER UTILITIES	
	GAS HEAT	44,781
	ELECTRICITY	45,789
	WATER	11,517
	CABLE TV - LOBBY	4,718
		0
		106,805
6	MAINTENANCE	
	GROUNDS MAINTENANCE	0
	PAINTING & DECORATING	0
	BUILDING REPAIRS	8,062
	MAINTENANCE TRAVEL	0
	EQUIPMENT MAINTENANCE & REPAIR	12,173
	ELEVATOR MAINTENANCE & REPAIR	3,820
	OUTSIDE LABOR	0
	EXTERMINATING SERVICE	2,700
	FIRE SERVICE	458
		0
		0
		0
		0
		27,213
7	OTHER	
	SCAVENGER	7,632
	SECURITY SERVICE	2,787
		0
		0
		10,419
9	MEDICAL DIRECTOR	
	MEDICAL DIRECTOR FEES XVIII B 36-2	21,000
		21,000

LINE	SCHED REF	TOTAL
10	NURSING	
	CONTRACT NURSING XVIII C 53-2	72,873
	LABORATORY & XRAY EXPENSE	5,056
	PURCHASED SERVICES	0
	PSYCHO-SOCIAL CONSULTANT XVIII B ___-2	0
	RESTORATIVE NURSING CONSULTANT XVIII B 38-2	0
	MEDICAL RECORDS CONSULTANT XVIII B 37-2	0
	PHARMACY CONSULTANT XVIII B 39-2	4,417
	UTILIZATION REVIEW FEES XVIII B ___-2	0
	PHYSICIANS XVIII B ___-2	0
	PSYCHIATRIC XVIII B ___-2	0
	RN CONSULTANT XVIII B 38-2	0
		0
		0
		82,346
10a	THERAPY	
	PHYSICAL THERAPY SERVICES	
	SPEECH THERAPY SERVICES	0
	OCCUPATIONAL THERAPY SERVICES	0
	REHABILITATION CONSULTANT XVIII B ___-2	0
	PHYSICAL THERAPY CONSULTANT XVIII B 40-2	0
	OCCUPATIONAL THERAPY CONSULTA XVIII B 41-2	0
	RESPIRATORY THERAPY CONSULTAN XVIII B 42-2	0
	SPEECH THERAPY CONSULTANT XVIII B 43-2	0
		0
11	ACTIVITIES	
	CABLE TV - PATIENT ROOMS	
	ACTIVITY REHAB CONSULTANT XVIII B 44-2	2,522
		0
		2,522
12	SOCIAL SERVICES	
	SOCIAL REHABILITATION SERVICES	
	SOCIAL REHABILITATION CONSULTAN XVIII B 45-2	0
	SOCIAL WORKER XVIII B 45-2	3,310
		0
		3,310
13	NURSE AIDE TRAINING	
	NURSE AIDE TRAINING COSTS XIII	0
		0

V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE	SCHED REF	TOTAL
14	PROGRAM TRANSPORTATION	
	PATIENT TRANSPORTATION	546
17	ADMINISTRATIVE	
	MANAGEMENT FEES XIX B	191,000
18	DIRECTORS FEES	
	DIRECTORS FEES	0
19	PROFESSIONAL SERVICES	
	DATA PROCESSING XIX C	15,568
	ADMINISTRATIVE CONSULTANTS XIX C	
	PROFESSIONAL FEES XIX C	34,990
		0
		50,558
20	FEES,SUBSCRIPTIONS,PROMOTIONS	
	ENTERTAINMENT & MARKETING VI 19 XIX F	0
	ADV & PROMO-NON PATIENT RELATED VI 25 XIX F	9,241
	EMPLOYEE WANT ADS XIX F	0
	CONTRIBUTIONS VI 20 XIX F	7,900
	DUES & SUBSCRIPTIONS XIX F	6,967
	LICENSES & PERMITS XIX F	5,210
	PUBLIC RELATIONS-PATIENT RELATED XIX F	0
	ADVERTISING-YELLOW PAGES VI 28 XIX F	0
	TRUST FEES / FRANCHISE TAX / ETC VI 17 XIX F	0
	CONTRIBUTIONS - POLITICAL VI 20 XIX F	4,036
	HEALTH CARE WORKER BACKGROUND CHEC XIX F	380
	PATIENT BACKGROUND CHECKS XIX F	0
		33,734
21	CLERICAL & GENERAL OFFICE EXPENSES	
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)	2,418
	EQUIPMENT REPAIR & MAINTENANCE	0
	OUTSIDE CLERICAL SERVICES	20,000
	PENALTIES / OVERDRAFT CHARGES VI 18	707
	HOME OFFICE EXPENSE	0
	THEFT & DAMAGE LOSS	1,347
	TELEPHONE	21,520
	MESSENGER SERVICE	0
		0
		45,992

LINE	SCHED REF	TOTAL
22	EMPLOYEE BENEFITS & PAYROLL TAXES	
	FICA TAXES XIX D	151,981
	UNEMPLOYMENT COMPENSATION XIX D	19,963
	WORKERS COMPENSATION INSURANC XIX D	37,561
	HOSPITALIZATION INSURANCE XIX D	82,794
	EMPLOYEE BENEFITS - OTHER XIX D	4,435
	EMPLOYEE PHYSICAL EXAMS XIX D	0
	INSURANCE - EXECUTIVE LIFE VI 21/XIX D	0
	PENSION/PROFIT SHARING PLANS XIX D	15,545
	CHICAGO HEAD TAX XIX D	4,200
		0
		316,479
23	INSERVICE TRAINING & EDUCATION	
	EDUCATION & SEMINARS	0
		0
24	TRAVEL & SEMINARS	
	EDUCATION & SEMINARS XIX G	302
	TRAVEL XIX G	0
		302
25	ADMIN. STAFF TRANSPORTATION	
	TRANSPORTATION - STAFF	4,668
		4,668
26	INSURANCE - PROP. LIAB & MALPRACTICE	
	GENERAL INSURANCE	117,516
		117,516
27	OTHER	
	BAD DEBTS VI 24	59,742
		59,742

GRAND TOTAL COLUMN 3 OTHER

1,074,152

LAKEFRONT NURSING & REHAB CTR
SCHEDULES
12/31/2008

EMPLOYEE MEAL RECLASSIFICATION
PAGE 3 SCHEDULE V COLUMN 5 LINES 2 AND 22

TOTAL FOOD PURCHASE	164,492
LESS SALES TAX	<u>(1,394)</u>
NET FOOD	163,098

TOTAL PATIENT CENSUS	33,651
TIME 3 MEALS PER DAY	<u>3</u>
TOTAL PATIENT MEALS	100,953

ADD # EMPLOYEE MEALS/DAY	45
TIME # DAYS	<u>366</u>
TOTAL EMPLOYEE MEALS	16,470

PATIENT MEALS	100,953
ADD EMPLOYEE MEALS	<u>16,470</u>
TOTAL MEALS/YEAR	117,423

NET FOOD	163,098
DIVIDE TOTAL MEALS/YEAR	<u>117,423</u>

COST PER MEAL	1.39
TIME EMPLOYEE MEALS	<u>16,470</u>
EMPLOYEE MEAL RECLASSIFICATION	22,893

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V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY	
		Salary/Wage	Supplies	Other	Total					9	10
	D. Ownership	1	2	3	4	5	6	7	8		
30	Depreciation			45,691	45,691		45,691	101,440	147,131		30
31	Amortization of Pre-Op. & Org.			1,774	1,774		1,774		1,774		31
32	Interest			32,415	32,415		32,415	289,354	321,769		32
33	Real Estate Taxes							107,141	107,141		33
34	Rent-Facility & Grounds			573,252	573,252		573,252	(573,252)			34
35	Rent-Equipment & Vehicles			15,517	15,517		15,517		15,517		35
36	Other (specify):* amort comp soft			10,198	10,198		10,198		10,198		36
37	TOTAL Ownership			678,847	678,847		678,847	(75,317)	603,530		37
	Ancillary Expense										
	E. Special Cost Centers										
38	Medically Necessary Transportation										38
39	Ancillary Service Centers		132,781	125,020	257,801		257,801		257,801		39
40	Barber and Beauty Shops										40
41	Coffee and Gift Shops										41
42	Provider Participation Fee			54,352	54,352		54,352		54,352		42
43	Other (specify):*										43
44	TOTAL Special Cost Centers		132,781	179,372	312,153		312,153		312,153		44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,999,373	470,523	1,970,636	4,440,532		4,440,532	(62,124)	4,378,408		45

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

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(24,447)	30		9
10	Interest and Other Investment Income	(1,854)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,394)	2		13
14	Non-Care Related Interest	(5,436)	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees		20		17
18	Fines and Penalties	(707)	21		18
19	Entertainment		20		19
20	Contributions	(11,936)	20		20
21	Owner or Key-Man Insurance		22		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(59,742)	27		24
25	Fund Raising, Advertising and Promotional	(9,241)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising		20		28
29	Other-Attach Schedule	(18,229)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (132,986)		\$	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)	70,862		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 70,862		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (62,124)		37

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

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

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

ID# 0047779

Report Period Beginning: 01/01/2008

Ending: 12/31/2008

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	DEFERRED MAINTENANCE	\$ 0	6	1
2	BANK CHARGES	(2,418)	21	2
3	MARKETING SALARY- MARIELLEN SULLIVAN	(11,143)	17	3
4	NON ALLOWABLE TRANSPORTATION	(4,668)	25	4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(18,229)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number LAKEFRONT NURSING & REHAB CTR

0047779

Report Period Beginning:

01/01/2008

Ending:

12/31/2008

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(1,394)	0	0	0	0	0	0	0	0	0	0	(1,394)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(1,394)	0	0	0	0	0	0	0	0	0	0	(1,394)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	(11,143)	2,338	21,387	36,000	13,778	0	0	0	0	0	0	62,360	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	529	1,527	3,720	0	0	0	0	0	0	0	5,776	19
20	Fees, Subscriptions & Promotions	(21,177)	935	0	0	0	0	0	0	0	0	0	(20,242)	20
21	Clerical & General Office Expenses	(3,125)	862	26,764	0	0	0	0	0	0	0	0	24,501	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	(4,668)	0	0	0	0	0	0	0	0	0	0	(4,668)	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	(59,742)	1,795	4,807	0	0	0	0	0	0	0	0	(53,140)	27
28	TOTAL General Administration	(99,855)	6,459	54,485	39,720	13,778	0	0	0	0	0	0	14,587	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(101,249)	6,459	54,485	39,720	13,778	0	0	0	0	0	0	13,193	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number LAKEFRONT NURSING & REHAB CTR # 0047779 Report Period Beginning: 01/01/2008 Ending: 12/31/2008

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(24,447)	0	0	125,887	0	0	0	0	0	0	0	101,440	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(7,290)	5,833	0	290,811	0	0	0	0	0	0	0	289,354	32
33	Real Estate Taxes	0	0	0	107,141	0	0	0	0	0	0	0	107,141	33
34	Rent-Facility & Grounds	0	0	0	(573,252)	0	0	0	0	0	0	0	(573,252)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(31,737)	5,833	0	(49,413)	0	0	0	0	0	0	0	(75,317)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(132,986)	12,292	54,485	(9,693)	13,778	0	0	0	0	0	0	(62,124)	45

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
MENACHEM SHABAT	70					
DONNA ATKIN	15			LAKEFRONT NURS &		
JOEL ATKIN	15			REHAB PROPERTIE	NILES	REAL ESTATE
		SEE ATTACHED SCHEDULE		INNOVATIVE		
				HEALTHCARE	NILES	BOOKKEEPING
				LEGACY		
				HEALTHCARE	SKOKIE	BOOKKEEPING

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	21 OUTSIDE CLERICAL	\$ 20,000	LEGACY HEALTHCARE		\$	(20,000)	1
2	V	17 mngt fee- chaim rajchenbach				1,169	1,169	2
3	V	17 mngt fee- menachem shabat				1,169	1,169	3
4	V	19 DATA PROCESSING				100	100	4
5	V	19 OTHER PROF FEES				429	429	5
6	V	20 DUES & SUBSRPTIONS				935	935	6
7	V	21 OFFICE				20,862	20,862	7
8	V	27 PAYROLL TAX/EMPL BEN				1,795	1,795	8
9	V	32 INTEREST				5,833	5,833	9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 20,000			\$ 32,292	\$ * 12,292	14

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	17 chief operating offic sal-lacek	\$	INNOVATIVE HEALTHCARE		\$ 12,246	\$ 12,246
16	V	17 cfo salary- orlinsky				9,141	9,141
17	V	19 professional fees				1,527	1,527
18	V	21 office expense				26,764	26,764
19	V	27 employee benefits				4,807	4,807
20	V						
21	V						
22	V						
23	V						
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$			\$ 54,485	\$ * 54,485

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	34 RENT	\$ 573,252			\$	\$ (573,252) 15
16	V	30 DEPRECIATION - SL				125,887	125,887 16
17	V	32 INTEREST				290,811	290,811 17
18	V	33 REAL ESTATE TAXES				107,141	107,141 18
19	V	17 MANAGEMENT FEES				36,000	36,000 19
20	V	19 PROFESSIONAL FEES				3,720	3,720 20
21	V						
22	V						
23	V						
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 573,252			\$ 563,559	\$ * (9,693) 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	17 admin salary- eli atkin	\$	IH MANAGEMENT		\$ 8,611	\$ 8,611	15
16	V	17 admin salary- donna atkin				5,167	5,167	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		\$			\$ 13,778	\$ * 13,778	39

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

Facility Name & ID Number LAKEFRONT NURSING & REHAB CTR # 0047779 Report Period Beginning: 01/01/2008 Ending: 12/31/2008

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	MENACHEM SHABAT	MEMBER	ADMINISTRAT.	70.00				mangemt fee	\$ 91,000	17-3	1
2								adminin cons	38,265	17-3	2
3								mangemt fee	1,169	17-7	3
4	JOEL ATKIN	MEMBER	ADMINISTRAT.	15.00				mangemt fee	44,000	17-3	4
5			ADMINISTRAT.								5
6											6
7	DONNA ATKIN	MEMBER	ADMINISTRAT.	15.00				mangemt fee	44,000	17-3	7
8								SALARY	5,167	17-7	8
9	ELI ATKIN		ADMIN.,PURCH					SALARY	8,611	17-7	9
10	HELEN LACEK	chief operating officer	ADMIN					SALARY	12,246	17-7	10
11	JAY ORLINSKY		ADMINISTRAT.					mangemt fee	36,000	17-7	11
12			ADMINISTRAT.					SALARY	9,141	17-7	12
13								TOTAL	\$ 289,599		13

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

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

Facility Name & ID Number LAKEFRONT NURSING & REHAB CTR

0047779 Report Period Beginning: 01/01/2008

Ending: 2/31/2008

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 LEGACY HEALTHCARE
 Street Address 9000 N LAVERGNE AVE
 City / State / Zip Code SKOKIE ILL 60077
 Phone Number (847) 679-2322
 Fax Number (847) 679-9325

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	17	mngt fee- chaim rajchenbach	PER RESIDENT DAY	34,133	\$ 3,500	\$	11,399	\$ 1,169	1
2	17	mngt fee- menachem shabat	PER RESIDENT DAY	34,133	3,500		11,399	1,169	2
3	19	DATA PROCESSING	PER RESIDENT DAY	34,133	300		11,399	100	3
4	19	OTHER PROF FEES	PER RESIDENT DAY	34,133	1,285		11,399	429	4
5	20	DUES & SUBSRIPTIONS	PER RESIDENT DAY	34,133	2,800		11,399	935	5
6	21	OFFICE	PER RESIDENT DAY	34,133	62,469	44,111	11,399	20,862	6
7	27	PAYROLL TAX/EMPL BEN	PER RESIDENT DAY	34,133	5,375		11,399	1,795	7
8	32	INTEREST	PER RESIDENT DAY	34,133	17,466		11,399	5,833	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				\$ 96,695	\$ 44,111		\$ 32,292	25

Facility Name & ID Number LAKEFRONT NURSING & REHAB CTR

0047779 Report Period Beginning: 01/01/2008

Ending: 2/31/2008

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 INNOVATIVE HEALTHCARE
 Street Address 9777 W. GREENWOOD
 City / State / Zip Code NILES, IL 60714-1002
 Phone Number (847) 470-0000
 Fax Number (847) 470-0061

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6		
1	17	chief operating offic sal-lacek	PATIENT DAYS	78,925	4	\$ 59,257	\$ 59,257	16,311	\$ 12,246	1
2	17	cfo salary- orlinsky	PATIENT DAYS	78,925	4	44,231	44,231	16,311	9,141	2
3	19	professional fees	PATIENT DAYS	78,925	4	7,391		16,311	1,527	3
4	21	office expense	PATIENT DAYS	78,925	4	129,505	114,775	16,311	26,764	4
5	27	employee benefits	PATIENT DAYS	78,925	4	23,262		16,311	4,807	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					\$ 263,646	\$ 218,263		\$ 54,485	25

Facility Name & ID Number LAKEFRONT NURSING & REHAB CTR

0047779 Report Period Beginning: 01/01/2008

Ending: 2/31/2008

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 LAKEFRONT NURSING & REHAB PROPERT
 Street Address 7618 N SHERIDAN ROAD
 City / State / Zip Code CHICAGO ILL 60626
 Phone Number (847) 679-2322
 Fax Number (847) 679-9325

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	30	DEPRECIATION - SL	DIRECT	1	\$ 125,887	\$	1	\$ 125,887	1
2	32	INTEREST	DIRECT	1	290,811		1	290,811	2
3	33	REAL ESTATE TAXES	DIRECT	1	107,141		1	107,141	3
4	17	MANAGEMENT FEES	DIRECT	1	36,000		1	36,000	4
5	19	PROFESSIONAL FEES	DIRECT	1	3,720		1	3,720	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				\$ 563,559	\$		\$ 563,559	25

Facility Name & ID Number LAKEFRONT NURSING & REHAB CTR

0047779

Report Period Beginning:

01/01/2008

Ending: 2/31/2008

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 I H MANAGEMENT
 Street Address 18300 S. LAVERGNE
 City / State / Zip Code TINLEY PARK ILL 60477
 Phone Number (708) 798-2272
 Fax Number (708) 798-2298

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	admin salary- eli atkin	PATIENT DAYS	78,925	4	\$ 41,667	\$ 41,667	16,311	\$ 8,611	1
2	17	admin salary- donna atkin	PATIENT DAYS	78,925	4	25,000	25,000	16,311	5,167	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					\$ 66,667	\$ 66,667		\$ 13,778	25

Facility Name & ID Number

LAKEFRONT NURSING & REHAB CTR

0047779

Report Period Beginning:

01/01/2008

Ending:

12/31/2008

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	Name of Lender	2		3	4	5	6		7	8	9	10						
		Related**					Purpose of Loan	Monthly Payment Required					Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO											Original	Balance			
	A. Directly Facility Related																	
	Long-Term																	
1							\$	\$				\$						
2																		
3	PREMIER BANK-REL PARTY		X	MORTGAGE	\$27,690.47	4/7/08		3,853,922	4/3/10			290,811						
4																		
5																		
	Working Capital																	
6	BANK FINANCIAL		X	WORKING CAPITAL	INT ONLY	DEMAND		177,039	REVOLV	PRIME+		20,685						
7	BANK FINANCIAL		X	CONSTRUCTION LOAN	\$1,830.75			72,789				6,294						
8																		
9	TOTAL Facility Related				\$29,521.22		\$	\$ 4,103,750				\$ 317,790						
	B. Non-Facility Related*																	
10																		
11	IDPA											5,436						
12																		
13																		
14	TOTAL Non-Facility Related						\$	\$				\$ 5,436						
15	TOTALS (line 9+line14)						\$	\$ 4,103,750				\$ 323,226						

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

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

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

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

B. Real Estate Taxes

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

1. Real Estate Tax accrual used on 2007 report.	\$	107,679	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.)	\$	107,410	2
3. Under or (over) accrual (line 2 minus line 1).	\$	(269)	3
4. Real Estate Tax accrual used for 2008 report. (Detail and explain your calculation of this accrual on the lines below.)	\$	107,410	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)	\$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)	\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	\$	107,141	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2003	169,659	8
	2004	121,703	9
	2005	122,943	10
	2006	107,679	11
	2007	107,410	12

FOR BHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2007	\$	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:

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

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 23,691 B. General Construction Type: Exterior BRICK Frame _____ Number of Stories _____

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

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

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

N/A

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

1. Total Amount Incurred: 26,610 2. Number of Years Over Which it is Being Amortized: 15
 3. Current Period Amortization: 1,774 4. Dates Incurred: 2006

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

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	NURSING HOME		2006	\$ 275,000	1
2					2
3	TOTALS			\$ 275,000	3

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9		
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	99			\$ 2,499,396	\$ 90,887	27.5	\$ 90,887	\$	\$ 246,152	4
5										5
6										6
7										7
8										8
Improvement Type**										
9	NEW FLOOR IN COOLER		2006	1,528	56	27.5	56		106	9
10	EXHAUST FAN		2006	2,400	87	27.5	87		167	10
11	SECURITY SYSTEM		2006	27,540	1,001	27.5	1,001		1,921	11
12	ELEVATOR REHAB		2006	17,126	623	27.5	623		1,193	12
13	WATER PUMP		2006	4,500	164	27.5	164		314	13
14	ELECTRICAL WORK		2006	2,175	79	27.5	79		151	14
15	NURSE CALL SYSTEM		2007	9,378	341	27.5	341		355	15
16	DOOR		2007	5,365	195	27.5	195		219	16
17	WIRING FOR CABLE		2007	15,700	571	27.5	571		738	17
18	PAINTING & WALLPAPER		2007	25,660	8,211	5	8,211		10,777	18
19	LIGHT FIXTURES		2007	6,431	234	27.5	234		341	19
20	CUSTOM NURSE STATION		2007	11,517	419	27.5	419		611	20
21	COVE BASE, VCT, VINYL SHEET		2007	22,486	818	27.5	818		1,193	21
22	HAND RAILS & BUMPERS		2007	6,434	234	27.5	234		341	22
23	DRAPERIES		2007	3,063	111	27.5	111		162	23
24	WALLCOVERINGS		2007	4,121	150	27.5	150		219	24
25	SHOWER REHAB		2008	4,600	77	27.5	77		77	25
26	BOILER		2008	10,700	178	27.5	178		178	26
27										27
28										28
29										29
30										30
31										31
32										32
33										33
34										34
35										35
36										36

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

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

See Page 12A, Line 70 for total

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67								67
68								68
69								69
70	TOTAL (lines 4 thru 69)	\$ 2,680,120	\$ 104,436		\$ 104,436	\$	\$ 265,215	70

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

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 64,155	\$ 16,789	\$ 6,416	\$ (10,373)	10	\$ 12,547	71
72	Current Year Purchases	25,588	15,353	1,279	(14,074)	10	1,279	72
73	Fully Depreciated Assets							73
74	RELATED PARTY	350,000	35,000	35,000			87,500	74
75	TOTALS	\$ 439,743	\$ 67,142	\$ 42,695	\$ (24,447)		\$ 101,326	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	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)	\$ 3,394,863	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 171,578	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 147,131	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (24,447)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 366,541	85

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

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

G. Construction-in-Progress

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

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: _____

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:		99		\$ 573,252			3
4	Additions							4
5								5
6								6
7	TOTAL		99		\$ 573,252			7

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

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

9. Option to Buy: YES NO Terms: _____*

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

15. Is Movable equipment rental included in building rental? YES NO

16. Rental Amount for movable equipment: \$ 15,517 Description: SEE SCHEDULE ATTACHED

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

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

Fiscal Year Ending Annual Rent

12. _____/2009 \$ _____

13. _____/2010 \$ _____

14. _____/2011 \$ _____

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

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

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39-3	hrs	\$		\$ 47,055	\$		\$ 47,055	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			35,191			35,191	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			41,883			41,883	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescripts				132,781		132,781	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): lab. Outside service					891			891	13
14	TOTAL			\$		\$ 125,020	\$ 132,781		\$ 257,801	14

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

Facility Name & ID Number LAKEFRONT NURSING & REHAB CTR

0047779

Report Period Beginning: 01/01/2008

Ending:

12/31/2008

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2008

(last day of reporting year)

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

		1	2	
		Operating	After	
			Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 41,801	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance (110,000))	912,961		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	38,262		6
7	Other Prepaid Expenses	4,253		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Employee Loan Assignmts</u>	5,188		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,002,465	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	155,064		15
16	Equipment, at Historical Cost	147,698		16
17	Accumulated Depreciation (book methods)	(103,131)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	26,610		19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(4,879)		20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 221,362	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,223,827	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 341,657	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	20,868		28
29	Short-Term Notes Payable	249,828		29
30	Accrued Salaries Payable	100,742		30
31	Accrued Taxes Payable (excluding real estate taxes)	10,945		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>License Fee</u>	13,662		36
37	<u>Due to Noeth Main</u>	71,292		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 808,994	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 808,994	\$	46
47	TOTAL EQUITY (page 18, line 24)	\$ 414,833	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,223,827	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 218,810	1
2	Restatements (describe):		2
3	Rounding	(1)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 218,809	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	397,024	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	(201,000)	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)	\$ 196,024	17
B. Transfers (Itemize):			
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)	\$ 414,833	24 *

* This must agree with page 17, line 47.

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

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

1

	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 4,835,702	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,835,702	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	1,854	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 1,854	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 4,837,556	30

2

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	771,153	31
32	Health Care	1,580,235	32
33	General Administration	1,098,144	33
	B. Capital Expense		
34	Ownership	678,847	34
	C. Ancillary Expense		
35	Special Cost Centers	257,801	35
36	Provider Participation Fee	54,352	36
	D. Other Expenses (specify):		
37	OUT-OF-PERIOD EXPENSES		37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 4,440,532	40
41	Income before Income Taxes (line 30 minus line 40)**	397,024	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 397,024	43

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

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

TAX RETURN PREPARED ON CASH BASIS

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

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

Facility Name & ID Number **LAKEFRONT NURSING & REHAB CTR**

0047779

Report Period Beginning: **01/01/2008**

Ending:

12/31/2008

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	1,665	1,804	\$ 49,646	\$ 27.52	1
2	Assistant Director of Nursing					2
3	Registered Nurses	15,961	16,742	419,138	25.04	3
4	Licensed Practical Nurses	10,410	10,976	226,789	20.66	4
5	CNAs & Orderlies	45,210	49,257	474,326	9.63	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	5,833	6,074	132,465	21.81	8
9	Activity Director	1,784	1,969	23,626	12.00	9
10	Activity Assistants	1,746	1,892	21,175	11.19	10
11	Social Service Workers	3,578	3,781	46,391	12.27	11
12	Dietician					12
13	Food Service Supervisor	794	817	15,717	19.24	13
14	Head Cook	1,976	2,304	29,472	12.79	14
15	Cook Helpers/Assistants	15,557	16,557	143,544	8.67	15
16	Dishwashers					16
17	Maintenance Workers	7,467	8,089	78,025	9.65	17
18	Housekeepers	9,382	10,631	95,611	8.99	18
19	Laundry	3,914	4,064	32,787	8.07	19
20	Administrator	3,825	3,914	122,665	31.34	20
21	Assistant Administrator	1,608	1,873	31,370	16.75	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	3,698	3,998	52,527	13.14	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	160	160	4,099	25.62	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	134,568	144,902	\$ 1,999,373 *	\$ 13.80	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	\$ 0	1-3	35	
36	Medical Director	42	21,000	9-3	36
37	Medical Records Consultant		0	10-3	37
38	Nurse Consultant		0	10-3	38
39	Pharmacist Consultant	294	4,417	10-3	39
40	Physical Therapy Consultant		0	10a-3	40
41	Occupational Therapy Consultant		0	10a-3	41
42	Respiratory Therapy Consultant		0	10a-3	42
43	Speech Therapy Consultant		0	10a-3	43
44	Activity Consultant	50	2,522	11-3	44
45	Social Service Consultant	59	3,310	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	445	\$ 31,249		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	\$	10-3	50	
51	Licensed Practical Nurses	2,438	72,873	10-3	51
52	Certified Nurse Assistants/Aides		10-3	52	
53	TOTAL (lines 50 - 52)	2,438	\$ 72,873		53

Facility Name & ID Number LAKEFRONT NURSING & REHAB CTR

0047779

Report Period Beginning: 01/01/2008

Ending: 12/31/2008

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? YES
- (2) Are there any dues to nursing home associations included on the cost report? YES
If YES, give association name and amount. ICLTC \$5468 IL assoc.of healthcare \$990
- (3) Did the nursing home make political contributions or payments to a political action organization? YES If YES, have these costs been properly adjusted out of the cost report? YES
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? YES
What was the average life used for new equipment added during this period? 10 YR
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ NO Line 10-2
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? NO
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? _____ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 54,352
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. \$ 22,893 Has any meal income been offset against related costs? N/A Indicate the amount. \$ _____
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? NO
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? 5%
d. Have vehicle usage logs been maintained? NO
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? NO
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? YES
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? NO
Firm Name: _____ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? _____ If no, please explain. _____
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? YES
- (19) If total legal fees are in excess of \$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