

Facility Name & ID Number LAKELAND REHAB & HCC

0045872 Report Period Beginning: 1/1/2008 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	123	Skilled (SNF)	109	44,164	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	123	TOTALS	109	44,164	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	17,294	16,191	6,080	39,565	8	
9	SNF/PED					9	
10	ICF					10	
11	ICF/DD					11	
12	SC					12	
13	DD 16 OR LESS					13	
14	TOTALS	17,294	16,191	6,080	39,565	14	

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 89.59%

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)

N/A- 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 6/8/1994

J. Was the facility purchased or leased after January 1, 1978?
YES Date 6/8/1994 NO

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 109 and days of care provided 6,080

Medicare Intermediary MUTUAL OF OMAHA

IV. ACCOUNTING BASIS

ACCRUAL 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 **LAKELAND REHAB & HCC** # **0045872** Report Period Beginning: **1/1/2008** 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	198,864	15,271	8,520	222,655		222,655	(3,435)	219,220		1
2	Food Purchase		222,286		222,286		222,286	(2,615)	219,671		2
3	Housekeeping		14,409	100,731	115,140		115,140		115,140		3
4	Laundry		15,156	67,156	82,312		82,312		82,312		4
5	Heat and Other Utilities			170,658	170,658		170,658		170,658		5
6	Maintenance	75,217	20,243	79,348	174,808		174,808		174,808		6
7	Other (specify):* TRASH REMOVAL			6,726	6,726		6,726		6,726		7
8	TOTAL General Services	274,081	287,365	433,139	994,585		994,585	(6,050)	988,535		8
B. Health Care and Programs											
9	Medical Director			7,418	7,418		7,418		7,418		9
10	Nursing and Medical Records	1,672,847	80,502	7,466	1,760,815		1,760,815		1,760,815		10
10a	Therapy		776	469,693	470,469		470,469		470,469		10a
11	Activities	81,477	1,293	9,278	92,048		92,048		92,048		11
12	Social Services	90,284	177	2,714	93,175		93,175		93,175		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,844,608	82,748	496,569	2,423,925		2,423,925		2,423,925		16
C. General Administration											
17	Administrative	99,804	284		100,088		100,088		100,088		17
18	Directors Fees										18
19	Professional Services			451,817	451,817		451,817	(12,000)	439,817		19
20	Dues, Fees, Subscriptions & Promotions			60,826	60,826		60,826	(35,213)	25,613		20
21	Clerical & General Office Expenses	105,331	35,709	122,801	263,841		263,841	(66,687)	197,154		21
22	Employee Benefits & Payroll Taxes			324,608	324,608		324,608		324,608		22
23	Inservice Training & Education			1,155	1,155		1,155		1,155		23
24	Travel and Seminar			3,623	3,623		3,623		3,623		24
25	Other Admin. Staff Transportation			15,532	15,532		15,532	(15,532)			25
26	Insurance-Prop.Liab.Malpractice			162,710	162,710		162,710		162,710		26
27	Other (specify):*										27
28	TOTAL General Administration	205,135	35,993	1,143,072	1,384,200		1,384,200	(129,432)	1,254,768		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,323,824	406,106	2,072,780	4,802,710		4,802,710	(135,482)	4,667,228		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.

Facility Name & ID Number

LAKELAND REHAB & HCC

#0045872

Report Period Beginning:

1/1/2008

Ending:

12/31/2008

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost 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	
	D. Ownership											
30	Depreciation			145,527	145,527		145,527		145,527			30
31	Amortization of Pre-Op. & Org.			2,026	2,026		2,026	(2,026)				31
32	Interest			45,299	45,299		45,299	(8,444)	36,855			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			7,176	7,176		7,176		7,176			35
36	Other (specify):*											36
37	TOTAL Ownership			200,028	200,028		200,028	(10,470)	189,558			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		205,711	131,296	337,007		337,007		337,007			39
40	Barber and Beauty Shops	121,416	50	(101,873)	19,593		19,593		19,593			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			77,525	77,525		77,525		77,525			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers	121,416	205,761	106,948	434,125		434,125		434,125			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,445,240	611,867	2,379,756	5,436,863		5,436,863	(145,952)	5,290,911			45

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

Facility Name & ID Number **LAKELAND REHAB & HCC**

0045872

Report Period Beginning: **1/1/2008**

Ending: **12/31/2008**

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	(3,435)	1		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				9
10	Interest and Other Investment Income	(8,444)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(2,615)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)	(15,532)	25		16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(667)	21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(12,000)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(31,787)	21		24
25	Fund Raising, Advertising and Promotional	(35,213)	20		25
26	Income Taxes and Illinois Personal				26
27	Property Replacement Tax				27
28	CNA Training for Non-Employees				28
29	Yellow Page Advertising				29
29	Other-Attach Schedule	(741)	21		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (110,434)		\$	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	(2,026)	31	33
34	Adjustments for Related Organization Costs (Schedule VII)	(33,492)	21	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (35,518)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (145,952)		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						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

LAKELAND REHAB & HCC

ID# 0045872

Report Period Beginning: 1/1/2008

Ending: 12/31/2008

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	MISC. INCOME	\$ (741)	21	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				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	(741)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number LAKELAND REHAB & HCC# 0045872

Report Period Beginning:

1/1/2008

Ending:

12/31/2008

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)	
	A. General Services													
1	Dietary	(3,435)	0	0	0	0	0	0	0	0	0	0	(3,435)	1
2	Food Purchase	(2,615)	0	0	0	0	0	0	0	0	0	0	(2,615)	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	(6,050)	0	0	0	0	0	0	0	0	0	0	(6,050)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(12,000)	0	0	0	0	0	0	0	0	0	0	(12,000)	19
20	Fees, Subscriptions & Promotions	(35,213)	0	0	0	0	0	0	0	0	0	0	(35,213)	20
21	Clerical & General Office Expenses	(66,687)	(33,492)	0	0	0	0	0	0	0	0	0	(100,179)	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	(15,532)	0	0	0	0	0	0	0	0	0	0	(15,532)	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(129,432)	(33,492)	0	(162,924)	28								
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(135,482)	(33,492)	0	(168,974)	29								

STATE OF ILLINOIS

Summary B

Facility Name & ID Number LAKELAND REHAB & HCC# 0045872

Report Period Beginning:

1/1/2008

Ending:

12/31/2008

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)
	D. Ownership												
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0 30
31	Amortization of Pre-Op. & Org.	(2,026)	0	0	0	0	0	0	0	0	0	0	(2,026) 31
32	Interest	(8,444)	0	0	0	0	0	0	0	0	0	0	(8,444) 32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0 33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0 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	(10,470)	0	0	0	0	0	0	0	0	0	0	(10,470) 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
	GRAND TOTAL COST												
45	(sum of lines 29, 37 & 44)	(145,952)	(33,492)	0	(179,444) 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
MIDWEST CARE CENTERS	100					

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 Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	21 CLERICAL & OTHER GEN OF	\$ 60,810	MIDWEST CARE CENTERS	100.00%	\$ 27,318	\$(33,492)	1
2	V							2
3	V							3
4	V							4
5	V							5
6	V							6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 60,810			\$ 27,318	\$ * (33,492)	14

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

Facility Name & ID Number LAKELAND REHAB & HCC # 0045872 Report Period Beginning: 1/1/2008 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									\$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13								TOTAL	\$	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 LAKELAND REHAB & HCC

0045872 Report Period Beginning: 1/1/2008

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 _____
 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	21	CLERICAL & OTHER GEN OF DIRECT COSTS	16,109,679	3	\$ 80,943	\$	5,436,865	\$ 27,318	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				\$ 80,943	\$		\$ 27,318	25

Facility Name & ID Number LAKELAND REHAB & HCC # 0045872 Report Period Beginning: 1/1/2008 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	2		3	4	5	6		7	8	9	10
		Related**					Amount of Note					
	Name of Lender	YES	NO	Purpose of Loan	Monthly Payment Required	Date of Note	Original	Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1	EFFINGHAM CLASS 4(D) BONDS	X		OPERATIONAL	VARIES	12/1/04	\$ 2,116,174	\$	8/2008	0.0700	\$ 45,299	1
2												2
3												3
4												4
5												5
	Working Capital											
6	INTERST INCOME		X	WORKING CAPITAL							(8,444)	6
7	PARENT CO	X		WORKING CAPITAL	VARIES		366,000	251,000				7
8												8
9	TOTAL Facility Related						\$ 2,482,174	\$ 251,000			\$ 36,855	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						\$	\$			\$	14
15	TOTALS (line 9+line14)						\$ 2,482,174	\$ 251,000			\$ 36,855	15

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

<p>Important, 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 2007 report.		\$	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.)		\$	2																								
3. Under or (over) accrual (line 2 minus line 1).		\$	3																								
4. Real Estate Tax accrual used for 2008 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	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.		\$	7																								
Real Estate Tax History:																											
Real Estate Tax Bill for Calendar Year:	<table border="1"> <tr><td>2003</td><td>8</td></tr> <tr><td>2004</td><td>9</td></tr> <tr><td>2005</td><td>10</td></tr> <tr><td>2006</td><td>11</td></tr> <tr><td>2007</td><td>12</td></tr> </table>	2003	8	2004	9	2005	10	2006	11	2007	12	<table border="1"> <tr><td colspan="2">FOR BHF USE ONLY</td></tr> <tr><td>13</td><td>FROM R. E. TAX STATEMENT FOR 2007 \$</td><td>13</td></tr> <tr><td>14</td><td>PLUS APPEAL COST FROM LINE 5 \$</td><td>14</td></tr> <tr><td>15</td><td>LESS REFUND FROM LINE 6 \$</td><td>15</td></tr> <tr><td>16</td><td>AMOUNT TO USE FOR RATE CALCULATION \$</td><td>16</td></tr> </table>		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
2003	8																										
2004	9																										
2005	10																										
2006	11																										
2007	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:

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.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates RE: 2007 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 2007 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2007.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2007 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 2008 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,

2007 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME LAKELAND REHAB & HCC COUNTY EFFINGHAM

FACILITY IDPH LICENSE NUMBER 0045872

CONTACT PERSON REGARDING THIS REPORT JUNIOR FOSTER, THCSLLC, MGMT CO

TELEPHONE (816) 444-0900 FAX #: (816) 822-1723

A. Summary of Real Estate Tax Cos

Enter the tax index number and real estate tax assessed for 2007 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 2007.

(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. _____	_____	\$ _____	\$ _____
TOTALS		\$ _____	\$ _____

B. Real Estate Tax Cost Allocation:

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 original 2007 tax bills which were listed in Section A to this statement. Be sure to use the 2007 tax bill which is normally paid during 2008

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.

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 50,500 B. General Construction Type: Exterior BRICK Frame BLOCK 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 ground (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)

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: 42,593 2. Number of Years Over Which it is Being Amortized: VARIOUS
 3. Current Period Amortization: 15,626 4. Dates Incurred: VARIOUS

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	LAND			\$ 30,248	1
2					2
3	TOTALS			\$ 30,248	3

Facility Name & ID Number LAKELAND REHAB & HCC

0045872

Report Period Beginning:

1/1/2008

Ending:

12/31/2008

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	109	2002	1971	\$ 1,840,770	\$ 61,359	30	\$ 61,359	\$	\$ 403,947	4
5										5
6										6
7										7
8										8
Improvement Type**										
9	TOTAL 2002 FIXED ASSET ADDITIONS		2002	101,052	6,111	VARIOUS	6,111		38,973	9
10	TOTAL 2003 FIXED ASSET ADDITIONS		2003	3,342	208	VARIOUS	208		2,168	10
11	RESIDENT ROOM TILE		2004	1,746	175	10	175		859	11
12	TILE FOR SHOWER		2004	845	84	10	84		401	12
13	UPGRADE HVAC SYSTEM		2004	23,133	2,313	10	2,313		10,988	13
14	REMAINING BALANCE ON A/C UNITS		2004	5,530	276	20	276		1,290	14
15	REMODEL SOFFIT		2004	284	28	10	28		118	15
16	WINDOW REPLACEMENT		2004	11,863	791	15	791		3,691	16
17	FLOOR COVERING		2004	22,061	2,206	10	2,206		9,192	17
18	SHOWER WALL REPAIR & FLOORING		2004	12,157	608	20	608		2,533	18
19	CONVERT 5 STALLS TO HANDICAPPED		2004	13,572	679	20	679		3,167	19
20	WALL REPAIR, WALL PAPER, PAINT		2004	12,626	2,525	5	2,525		10,522	20
21	ADA SITE VISIT FOR STALL CONVERSION		2004	4,594	919	5	919		4,288	21
22	REMODEL RESIDENT ROOMS		2004	2,730	273	10	273		1,115	22
23	FLOOR COVERING		2004	735	74	10	74		331	23
24	FLOOR COVERING		2004	735	74	10	74		301	24
25	DOOR LOCKS		2004	761	152	5	152		710	25
26	FRONT DOOR		2004	728	73	10	73		334	26
27	DOUBLE DOORS FOR ENTRANCE		2004	5,735	573	10	573		2,628	27
28	DROP IN LIGHTING		2004	7,363	736	10	736		3,191	28
29	WALLPAPER DINING ROOM & HALLWAYS		2004	13,798	2,759	5	2,759		11,498	29
30	CEILING TILES		2004	14,025	1,402	10	1,402		6,428	30
31	CEILING TILES		2004	6,134	613	10	613		3,016	31
32	BIOLER ROOM DOORS		2004	5,445	363	15	363		1,543	32
33	LANDSCAPING		2004	4,500	450	10	450		2,100	33
34	SIGN		2004	4,380	438	10	438		1,898	34
35	FIRE SUPPRESSION SYSTEM		2005	1,675	67	25	67		235	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

Facility Name & ID Number LAKELAND REHAB & HCC

0045872

Report Period Beginning:

1/1/2008

Ending:

12/31/2008

XI. OWNERSHIP COSTS (continued)

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

	1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
37	PARKING LOT PAVING	2005	\$ 36,630	\$ 4,579	8	\$ 4,579	\$	\$ 14,499	37	
38	LABOR TO RENOVATIONS RE: PATIENT ROOMS	2005	6,900	690	10	690		2,645	38	
39	FOUNTAIN RESTORATION	2005	4,501	300	15	300		938	39	
40	PAINTING	2005	5,408	1,082	5	1,082		3,425	40	
41	PAINTING WINDOW TRIM	2005	750	150	5	150		475	41	
42	SIDEWALK	2006	1,455	97	15	97		224	42	
43	SMOKE DETECTOR	2005	658	66	10	66		203	43	
44	FRAMEWORK AND PAINTING OF EXTERIOR DOORS	2005	675	135	5	135		427	44	
45	LOUVERED SHUTTERS	2006	871	124	7	124		363	45	
46	PARKING BLOCKS AND PINS	2006	956	191	5	191		542	46	
47	REMODELED ROOMS	2006	1,152	165	7	165		406	47	
48	ROOF REPLACEMENT	2006	172,157	17,216	10	17,216		45,905	48	
49	FIRE ALARM EQUIPMENT FOR HALLS	2006	8,385	839	10	839		2,237	49	
50	POCKET DOORS	2006	3,646	182	20	182		422	50	
51	DOORS AND FRAMES	2006	1,976	99	20	99		265	51	
52	CARPET FOR FRONT ENTRANCE	2006	550	110	5	110		257	52	
53	OUTSIDE LIGHTING	2006	13,133	1,313	10	1,313		2,914	53	
54	HALL SHOWER/ BATHROOM	2006	1,063	89	12	89		185	54	
55	FEEDER ROOM	2007	1,522	217	7	217		417	55	
56	LOUNGE AND LOBBY FLOORS	2007	4,338	868	5	868		1,518	56	
57	SEAL STAFF PARKING LOT	2007	5,000	714	7	714		1,190	57	
58	WINDOWS 4 VINYL SIDING	2007	3,008	201	15	201		267	58	
59	THERAPY ROOM BLDG	2007	18,172	909	20	909		1,205	59	
60	HAND RAILING	2008	604	40	15	40		40	60	
61	POCKET DOORS	2008	989	55	15	55		55	61	
62	THERAPY ROOM BLDG	2008	291	18	15	18		18	62	
63	CARPET 200 & 300 HALL	2008	1,200	157	7	157		157	63	
64	TOILET REPAIR	2008	582	49	5	49		49	64	
65	RESIDENT ROOM FLOOR COVERING	2004	621	62	10	62		373	65	
66									66	
67									67	
68									68	
69									69	
70	TOTAL (lines 4 thru 69)		\$ 2,419,512	\$ 117,046		\$ 117,046	\$	\$ 609,086	70	

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

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	\$ 306,528	\$ 26,248	\$ 26,248	\$		\$ 183,194	71
72	Current Year Purchases	14,496	2,233	2,233			2,260	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 321,024	\$ 28,481	\$ 28,481	\$		\$ 185,454	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	2	
	Reference	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)	\$ 2,770,784	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 145,527	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 145,527	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 794,540	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:	<u>N/A</u>			\$ _____			3
4	Additions							4
5								5
6								6
7	TOTAL				\$ _____			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.	_____ /2009	\$ _____
13.	_____ /2010	\$ _____
14.	_____ /2011	\$ _____

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: \$ 7,176 Description: _____

(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.

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. CLASSROOM PORTION:</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. CLINICAL PORTION:</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			Total
		1 Drop-outs	2 Completed	3 Contract	
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)	\$			

- (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.

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	

- (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	1 Schedule V Line & Column Reference	2		3		4		5		6 Supplies (Actual or Allocated)	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)	
			Staff		Outside Practitioner (other than consultant)		Units	Cost						
			Units of Service	Cost	Units	Cost								
1	Licensed Occupational Therapist	10a,3	hrs	\$	2,133	\$	129,213	\$			2,133	\$	129,213	1
2	Licensed Speech and Language Development Therapist	10a,3	hrs		1,393		101,940				1,393		101,940	2
3	Licensed Recreational Therapist		hrs											3
4	Licensed Physical Therapist	10a,3	hrs		4,007		238,540				4,007		238,540	4
5	Physician Care		visits											5
6	Dental Care		visits											6
7	Work Related Program		hrs											7
8	Habilitation		hrs											8
9	Pharmacy		# of prescripts											9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs											10
11	Academic Education		hrs											11
12	Other (specify):													12
13	Other (specify):													13
14	TOTAL			\$	7,533	\$	469,693	\$			7,533	\$	469,693	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.

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	\$ 119,550	\$	1
2	Cash-Patient Deposits	21,284		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	904,526		3
4	Supply Inventory (priced at)	12,271		4
5	Short-Term Investments			5
6	Prepaid Insurance	39,615		6
7	Other Prepaid Expenses	1,235		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,098,481	\$	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	30,248		13
14	Buildings, at Historical Cost	2,409,176		14
15	Leasehold Improvements, at Historical Cost	10,335		15
16	Equipment, at Historical Cost	321,024		16
17	Accumulated Depreciation (book methods)	(794,540)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	52,494		19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(46,047)		20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): WORK IN PROGRESS	122,474		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 2,105,164	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 3,203,645	\$	25

		1	2	
		Operating	After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 451,361	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	21,284		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	187,351		30
31	Accrued Taxes Payable (excluding real estate taxes)	30,324		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	OTHER ACCRUED EXPENSES	47,012		36
37	OTHER CURRENT LIABILITIES	251,000		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 988,332	\$	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)	\$ 988,332	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 2,215,313	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 3,203,645	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,566,804	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,566,804	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	948,509	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 948,509	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)	\$ 2,515,313	24 *

* This must agree with page 17, line 47.

STATE OF ILLINOIS

Facility Name & ID Number LAKELAND REHAB & HCC

0045872

Report Period Beginning: 1/1/2008

Ending:

Page 19

12/31/2008

VII. 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	\$ 4,740,217	1
2	Discounts and Allowances for all Levels	(30,925)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,709,292	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	781,523	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 781,523	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	662	13
14	Non-Patient Meals	3,435	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	652,365	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	33,543	19
20	Radiology and X-Ray		20
21	Other Medical Services	195,367	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 885,372	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	8,444	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 8,444	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	MISC INCOME	741	28
28a	PRIOR YEAR ADJUSTMENT		28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 741	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 6,385,372	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	994,585	31
32	Health Care	2,423,925	32
33	General Administration	1,384,200	33
B. Capital Expense			
34	Ownership	200,028	34
C. Ancillary Expense			
35	Special Cost Centers	356,600	35
36	Provider Participation Fee	77,525	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 5,436,863	40
41	Income before Income Taxes (line 30 minus line 40)**	948,509	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 948,509	43

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? _____ 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.

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

Facility Name & ID Number LAKELAND REHAB & HCC

0045872

Report Period Beginning: 1/1/2008

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	13,153	13,318	\$ 320,653	\$ 24.08	1
2	Assistant Director of Nursing					2
3	Registered Nurses	7,251	7,362	173,281	23.54	3
4	Licensed Practical Nurses	20,618	20,760	383,168	18.46	4
5	CNAs & Orderlies	67,105	67,542	735,942	10.90	5
6	CNA Trainees	3,153	3,236	41,160	12.72	6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	5,521	6,181	81,477	13.18	10
11	Social Service Workers	6,011	6,089	90,285	14.83	11
12	Dietician	21,584	21,733	198,864	9.15	12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers	5,650	5,706	75,217	13.18	17
18	Housekeepers					18
19	Laundry					19
20	Administrator	2,008	2,024	105,842	52.29	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	6,481	6,593	98,165	14.89	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,809	1,847	19,772	10.70	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	160,344	162,391	\$ 2,323,826 *	\$ 14.31	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	\$		35
36	Medical Director			36
37	Medical Records Consultant			37
38	Nurse Consultant			38
39	Pharmacist Consultant			39
40	Physical Therapy Consultant			40
41	Occupational Therapy Consultant			41
42	Respiratory Therapy Consultant			42
43	Speech Therapy Consultant			43
44	Activity Consultant			44
45	Social Service Consultant			45
46	Other(specify)			46
47				47
48				48
49	TOTAL (lines 35 - 48)	\$		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

Facility Name & ID Number LAKELAND REHAB & HCC

XIX. SUPPORT SCHEDULES

A. Administrative Salaries			D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions		
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
STEPHEN HOPKINS	ADMINISTRATOR		\$ 99,804	Workers' Compensation Insurance	\$ 97,143	IDPH License Fee	\$	
				Unemployment Compensation Insurance		Advertising: Employee Recruitment	9,200	
				FICA Taxes	169,081	Health Care Worker Background Check (Indicate # of checks performed _____)		
				Employee Health Insurance	42,347	Patient Background Checks		
				Employee Meals		ADVERTISING & PR	35,213	
				Illinois Municipal Retirement Fund (IMRF)*		DUES & SUBSCRIPTIONS	14,098	
				OTHER BENEFITS	29,076	LICENSES	2,315	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 99,804					
B. Administrative - Other								
Description			Amount					
			\$					
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$					
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount
PLEASE SEE ATTACHED	DATA PROCESSING FEES		17,244			\$	Out-of-State Travel	\$
PLEASE SEE ATTACHED	LEGAL FEES		200					
PINNACLE CONSULTING	PROFESSIONAL FEES		840					
PLEASE SEE ATTACHED	PURCHASED SERVICES		37,403				In-State Travel	3,623
BKD, LLP	ACCOUNTING FEES		19,273					
TUTERA HEALTH CARE SERVICE	MANAGEMENT FEES		364,857				Seminar Expense	
PLEASE SEE ATTACHED	RETAINER FEES		12,000					
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 451,817	TOTAL		\$	Entertainment Expense (agree to Sch. V, line 24, col. 8)	
							TOTAL	\$ 3,623

* Attach copy of IMRF notifications

**See instructions.

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? YES
If YES, give association name and amount. 7783 ILLINOIS HEALTH CARE ASSOCIATION
- (3) Did the nursing home make political contributions or payments to a political organization? NO If YES, have these costs been properly adjusted out of the cost report? N/A
- (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? N/A
- (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? 7
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 7,594 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. N/A
- (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. \$ 77,525
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 benefit: on Schedule V. \$ N/A Has any meal income been offset against related costs? YES Indicate the amount. \$ 3,435
- (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. \$ N/A
c. What percent of all travel expense relates to transportation of nurses and patients? 0
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? NO
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: 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? NO 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.