

Facility Name & ID Number LAKEVIEW NURSING & REHABILITATION CENTRE

0026484 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	178	Skilled (SNF)	178	65,148	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	178	TOTALS	178	65,148	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	1,400	175	12,384	13,959	8
9	SNF/PED					9
10	ICF	36,622	4,817	118	41,557	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	38,022	4,992	12,502	55,516	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 85.22%

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 08/15/81

J. Was the facility purchased or leased after January 1, 1978?
YES Date 08/14/81 NO

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 178 and days of care provided 10,303

Medicare Intermediary ADMINISTAR

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 LAKEVIEW NURSING & REHABILITATION # 0026484 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				Reclassification 5	Reclassified Total 6	Adjustments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	341,733	49,187	27,557	418,477		418,477		418,477		1
2	Food Purchase		348,129		348,129	(21,521)	326,608		326,608		2
3	Housekeeping	339,651	37,766		377,417		377,417		377,417		3
4	Laundry	78,732	29,162	979	108,873		108,873		108,873		4
5	Heat and Other Utilities			214,961	214,961		214,961	887	215,848		5
6	Maintenance	108,945	35,523	31,033	175,501		175,501	(2,310)	173,191		6
7	Other (specify):*			25,676	25,676		25,676		25,676		7
8	TOTAL General Services	869,061	499,767	300,206	1,669,034	(21,521)	1,647,513	(1,423)	1,646,090		8
	B. Health Care and Programs										
9	Medical Director			90,000	90,000		90,000		90,000		9
10	Nursing and Medical Records	3,120,911	263,175	34,332	3,418,418		3,418,418		3,418,418		10
10a	Therapy	620,300	1,394		621,694		621,694		621,694		10a
11	Activities	121,662	7,788	29,319	158,769		158,769		158,769		11
12	Social Services	99,016		1,829	100,845		100,845		100,845		12
13	CNA Training										13
14	Program Transportation			1,463	1,463		1,463		1,463		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	3,961,889	272,357	156,943	4,391,189		4,391,189		4,391,189		16
	C. General Administration										
17	Administrative	224,885		385,000	609,885		609,885	(385,000)	224,885		17
18	Directors Fees										18
19	Professional Services			118,264	118,264		118,264	179	118,443		19
20	Dues, Fees, Subscriptions & Promotions			140,438	140,438		140,438	(72,289)	68,149		20
21	Clerical & General Office Expenses	476,582	68,301	94,673	639,556		639,556	(56,884)	582,672		21
22	Employee Benefits & Payroll Taxes			1,031,163	1,031,163	21,521	1,052,684		1,052,684		22
23	Inservice Training & Education										23
24	Travel and Seminar			8,492	8,492		8,492		8,492		24
25	Other Admin. Staff Transportation			21,837	21,837		21,837	7,648	29,485		25
26	Insurance-Prop.Liab.Malpractice			154,221	154,221		154,221	13,349	167,570		26
27	Other (specify):*			12,249	12,249		12,249	(5,959)	6,290		27
28	TOTAL General Administration	701,467	68,301	1,966,337	2,736,105	21,521	2,757,626	(498,956)	2,258,670		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	5,532,417	840,425	2,423,486	8,796,328		8,796,328	(500,379)	8,295,949		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	25,599
	REPAIRS & MAINTENANCE	1,958
		0
		27,557
3	HOUSEKEEPING	
		0
		0
		0
4	LAUNDRY	
	EQUIPMENT REPAIRS & MAINTENANCE	979
		0
		979
5	HEAT & OTHER UTILITIES	
	GAS HEAT	101,052
	ELECTRICITY	92,747
	WATER	21,162
	CABLE TV - LOBBY	0
		0
		214,961
6	MAINTENANCE	
	GROUNDS MAINTENANCE	4,237
	PAINTING & DECORATING	3,286
	BUILDING REPAIRS	0
	MAINTENANCE TRAVEL	0
	EQUIPMENT MAINTENANCE & REPAIR	7,763
	ELEVATOR MAINTENANCE & REPAIR	8,671
	OUTSIDE LABOR	0
	EXTERMINATING SERVICE	3,654
	FIRE SERVICE	3,422
		0
		0
		0
		0
		31,033
7	OTHER	
	SCAVENGER	23,005
	SECURITY SERVICE	2,671
		0
		0
		25,676
9	MEDICAL DIRECTOR	
	MEDICAL DIRECTOR FEES XVIII B 36-2	90,000
		90,000

LINE	SCHED REF	TOTAL
10	NURSING	
	CONTRACT NURSING XVIII C 53-2	
	LABORATORY & XRAY EXPENSE	0
	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	4,320
	PHARMACY CONSULTANT XVIII B 39-2	0
	UTILIZATION REVIEW FEES XVIII B ___-2	0
	PHYSICIANS XVIII B ___-2	0
	PSYCHIATRIC XVIII B ___-2	0
	RN CONSULTANT XVIII B 38-2	0
	NURSING PROGRAM CONSULTANT	30,012
		0
		34,332
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	26,875
	ACTIVITY REHAB CONSULTANT XVIII B 44-2	2,444
		0
		29,319
12	SOCIAL SERVICES	
	SOCIAL REHABILITATION SERVICES	
	SOCIAL REHABILITATION CONSULTAN XVIII B 45-2	0
	SOCIAL WORKER XVIII B 45-2	1,829
		0
		1,829
13	NURSE AIDE TRAINING	
	NURSE AIDE TRAINING COSTS XIII	0

V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE	SCHED REF	TOTAL
14	PROGRAM TRANSPORTATION	
	PATIENT TRANSPORTATION	1,463
17	ADMINISTRATIVE	
	MANAGEMENT FEES XIX B	385,000
	DIRECTORS FEES	
18	DIRECTORS FEES	0
19	PROFESSIONAL SERVICES	
	DATA PROCESSING XIX C	13,519
	ADMINISTRATIVE CONSULTANTS XIX C	0
	PROFESSIONAL FEES XIX C	104,745
		0
		118,264
20	FEES,SUBSCRIPTIONS,PROMOTIONS	
	ENTERTAINMENT & MARKETING VI 19 XIX F	57,955
	ADV & PROMO-NON PATIENT RELATED VI 25 XIX F	827
	EMPLOYEE WANT ADS XIX F	38,341
	CONTRIBUTIONS VI 20 XIX F	3,080
	DUES & SUBSCRIPTIONS XIX F	16,305
	LICENSES & PERMITS XIX F	3,309
	PUBLIC RELATIONS-PATIENT RELATED XIX F	0
	ADVERTISING-YELLOW PAGES VI 28 XIX F	4,615
	TRUST FEES / FRANCHISE TAX / ETC VI 17 XIX F	0
	CONTRIBUTIONS - POLITICAL VI 20 XIX F	7,756
	HEALTH CARE WORKER BACKGROUND CHEC XIX F	5,936
	PATIENT BACKGROUND CHECKS XIX F	2,314
		140,438
21	CLERICAL & GENERAL OFFICE EXPENSES	
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)	11,080
	EQUIPMENT REPAIR & MAINTENANCE	34,413
	OUTSIDE CLERICAL SERVICES	0
	PENALTIES / OVERDRAFT CHARGES VI 18	4,218
	HOME OFFICE EXPENSE	0
	THEFT & DAMAGE LOSS	0
	TELEPHONE	43,368
	MESSENGER SERVICE	1,594
		0
		94,673

LINE	SCHED REF	TOTAL
22	EMPLOYEE BENEFITS & PAYROLL TAXES	
	FICA TAXES XIX D	420,800
	UNEMPLOYMENT COMPENSATION XIX D	51,603
	WORKERS COMPENSATION INSURANC XIX D	156,511
	HOSPITALIZATION INSURANCE XIX D	344,255
	EMPLOYEE BENEFITS - OTHER XIX D	12,046
	EMPLOYEE PHYSICAL EXAMS XIX D	0
	INSURANCE - EXECUTIVE LIFE VI 21/XIX D	0
	PENSION/PROFIT SHARING PLANS XIX D	37,348
	CHICAGO HEAD TAX XIX D	8,600
		0
		1,031,163
23	INSERVICE TRAINING & EDUCATION	
	EDUCATION & SEMINARS	0
		0
24	TRAVEL & SEMINARS	
	EDUCATION & SEMINARS XIX G	8,492
	TRAVEL XIX G	0
		8,492
25	ADMIN. STAFF TRANSPORTATION	
	TRANSPORTATION - STAFF	21,837
		21,837
26	INSURANCE - PROP. LIAB & MALPRACTICE	
	GENERAL INSURANCE	154,221
		154,221
27	OTHER	
	BAD DEBTS VI 24	12,249
		12,249

GRAND TOTAL COLUMN 3 OTHER

2,423,486

**LAKEVIEW NURSING & REHABILITATION CENTRE
SCHEDULES
12/31/2008**

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

TOTAL FOOD PURCHASE	348,129
LESS SALES TAX	<u>0</u>
NET FOOD	348,129

HAVE YOU FORGOTTEN TO ENTER SALES TAX ON PAGE 5??

TOTAL PATIENT CENSUS	55,516
TIME 3 MEALS PER DAY	<u>3</u>
TOTAL PATIENT MEALS	166,548

ADD # EMPLOYEE MEALS/DAY	30
TIME # DAYS	<u>366</u>
TOTAL EMPLOYEE MEALS	10,980

PATIENT MEALS	166,548
ADD EMPLOYEE MEALS	<u>10,980</u>
TOTAL MEALS/YEAR	177,528

NET FOOD	348,129
DIVIDE TOTAL MEALS/YEAR	<u>177,528</u>

COST PER MEAL	1.96
TIME EMPLOYEE MEALS	<u>10,980</u>
EMPLOYEE MEAL RECLASSIFICATION	21,521

=====

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			168,322	168,322		168,322	205,686	374,008			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			194,491	194,491		194,491	593,408	787,899			32
33	Real Estate Taxes							166,343	166,343			33
34	Rent-Facility & Grounds			942,715	942,715		942,715	(924,715)	18,000			34
35	Rent-Equipment & Vehicles			97,475	97,475		97,475		97,475			35
36	Other (specify):* OFFICE RENT			19,104	19,104		19,104		19,104			36
37	TOTAL Ownership			1,422,107	1,422,107		1,422,107	40,722	1,462,829			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		459,385	35,928	495,313		495,313		495,313			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			97,722	97,722		97,722		97,722			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		459,385	133,650	593,035		593,035		593,035			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	5,532,417	1,299,810	3,979,243	10,811,470		10,811,470	(459,657)	10,351,813			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	(1,453)	30		9
10	Interest and Other Investment Income	(34)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax		2		13
14	Non-Care Related Interest		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	(4,218)	21		18
19	Entertainment	(57,955)	20		19
20	Contributions	(10,836)	20		20
21	Owner or Key-Man Insurance		22		21
22	Special Legal Fees & Legal Retainers	(2,560)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(12,249)	27		24
25	Fund Raising, Advertising and Promotional	(827)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(4,615)	20		28
29	Other-Attach Schedule SEE PAGE 5A	(149,659)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (244,406)		\$	30

BHF USE ONLY							
48		49		50		51	

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)	(215,251)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (215,251)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (459,657)		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

STATE OF ILLINOIS
 LAKEVIEW NURSING & REHABILITATION CENTRE

ID# 0026484

Report Period Beginning: 01/01/2008

Ending: 12/31/2008

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	DEFERRED MAINTENANCE	\$ (2,310)	6	1
2	MARKETING SALARIES	(147,349)	21	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	(149,659)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number LAKEVIEW NURSING & REHABILITATION CENTRE

0026484

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	0	0	0	0	0	0	0	0	0	0	0	0	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	887	0	0	0	0	0	0	0	0	887	5
6	Maintenance	(2,310)	0	0	0	0	0	0	0	0	0	0	(2,310)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(2,310)	0	887	0	(1,423)	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	(385,000)	0	0	0	0	0	0	0	0	(385,000)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(2,560)	0	2,739	0	0	0	0	0	0	0	0	179	19
20	Fees, Subscriptions & Promotions	(74,233)	0	1,944	0	0	0	0	0	0	0	0	(72,289)	20
21	Clerical & General Office Expenses	(151,567)	0	94,683	0	0	0	0	0	0	0	0	(56,884)	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	0	0	7,648	0	0	0	0	0	0	0	0	7,648	25
26	Insurance-Prop.Liab.Malpractice	0	13,349	0	0	0	0	0	0	0	0	0	13,349	26
27	Other (specify):*	(12,249)	0	6,290	0	0	0	0	0	0	0	0	(5,959)	27
28	TOTAL General Administration	(240,609)	13,349	(271,696)	0	(498,956)	28							
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(242,919)	13,349	(270,809)	0	(500,379)	29							

STATE OF ILLINOIS

Summary B

Facility Name & ID Number LAKEVIEW NURSING & REHABILITATION CENTRE

0026484

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 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	(1,453)	207,139	0	0	0	0	0	0	0	0	0	205,686	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(34)	593,442	0	0	0	0	0	0	0	0	0	593,408	32
33	Real Estate Taxes	0	166,343	0	0	0	0	0	0	0	0	0	166,343	33
34	Rent-Facility & Grounds	0	(942,715)	18,000	0	0	0	0	0	0	0	0	(924,715)	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	(1,487)	24,209	18,000	0	40,722	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)	(244,406)	37,558	(252,809)	0	(459,657)	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
SAM BOREK	50			BOREK & GOLDHIRSCH	WILMETTE	LAW FIRM
HILLARD GARLOVSKY	50			CONSULTANT FOR CORPORATE MGMT	WILMETTE	MGMT/CLERICAL
				735 W. DIVERSEY BUILDING, LLC	CHICAGO	REAL ESTATE

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	34 RENT	\$ 942,715	735 WEST DIVERSEY BUILDING, LLC		\$	(942,715)	1
2	V	30 SL DEPRECIATION		" " " " "		207,139	207,139	2
3	V	32 INTEREST		" " " " "		545,269	545,269	3
4	V	33 REAL ESTATE TAX		" " " " "		166,343	166,343	4
5	V	32 MORTGAGE INSURANCE		" " " " "		48,173	48,173	5
6	V	26 INSURANCE		" " " " "		13,349	13,349	6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 942,715			\$ 980,273	\$ * 37,558	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 MANAGEMENT FEES	\$ 385,000	CONSULTANT FOR CORPORATE MANAGEMENT		\$	\$ (385,000)
16	V						
17	V						
18	V	5 UTILITIES				887	887
19	V	19 DATA PROCESSING				2,739	2,739
20	V	20 DUES AND SUBSCRIPTIONS				1,944	1,944
21	V	21 TOTAL OFFICE				94,683	94,683
22	V	25 TRANSPORTATION				7,648	7,648
23	V	27 EMPLOYEE BENEFITS				6,290	6,290
24	V	34 OFFICE RENT				18,000	18,000
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		\$ 385,000			\$ 132,191	\$ * (252,809)

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

Facility Name & ID Number LAKEVIEW NURSING & REHABILITAT # 0026484 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	SAM BOREK	PRESIDENT	ADMINISTRAT.	50.00		30	60.00	SALARY	\$ 42,386	17-1	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	\$ 42,386		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 LAKEVIEW NURSING & REHABILITATION CENTRE # 0026484 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 CONSULTANTS FOR CORPORATE MGMT
 Street Address 345 LAKE AVENUE
 City / State / Zip Code WILMETTE, IL 60091
 Phone Number (847) 784-8204
 Fax Number (847) 784-8248

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	5	UTILITIES	DIRECT COST		\$ 887	\$		\$ 887	1
2	19	DATA PROCESSING	DIRECT COST		2,739			2,739	2
3	20	DUES AND SUBSCRIPTIONS	DIRECT COST		1,944			1,944	3
4	21	TOTAL OFFICE	DIRECT COST		94,683	74,834		94,683	4
5	25	TRANSPORTATION	DIRECT COST		7,648			7,648	5
6	27	EMPLOYEE BENEFITS	DIRECT COST		6,290			6,290	6
7	34	OFFICE RENT	DIRECT COST		18,000			18,000	7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 132,191	\$ 74,834		\$ 132,191	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	2	3	4	5	6	7	8	9	10											
										Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
											YES	NO				Original	Balance			
A. Directly Facility Related																				
Long-Term																				
1	RELATED PARTY: 735 DIVERSEY BUILDING, LLC				\$	\$			\$	1										
2	CAMBRIDGE REALTY	X	MORTGAGE	\$77,801.29	05/04	10,055,500	9,601,497	05/39	5.6000	539,581	2									
3	LOAN COSTS	X	LOAN COSTS	W/O OVER LOAN		199,085	172,777			5,688	3									
4	PROVIDENCE CAPITAL	X	EQUIPMANT LEASE	\$23,085.00	11/07	950,226	729,739	12/11	8.6450	72,773	4									
5	MIP INSURANCE	X								48,173	5									
Working Capital																				
6	BANK FINANCIAL	X	WORKING CAPITAL	DEMAND	12/07	2,412,203	2,412,203		3.2500	115,676	6									
7	GLENVIEW STATE BANK	X	AUTO LOAN							451	7									
8	MEPCO INSURANCE	X	INSURANCE FINANCE							5,591	8									
9	TOTAL Facility Related			\$100,886.29		\$ 13,617,014	\$ 12,916,216			\$ 787,933	9									
B. Non-Facility Related*																				
10											10									
11											11									
12											12									
13											13									
14	TOTAL Non-Facility Related					\$	\$			\$	14									
15	TOTALS (line 9+line14)					\$ 13,617,014	\$ 12,916,216			\$ 787,933	15									

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 48,173 Line # 32-7

* 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.		\$	178,465	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.)		\$	168,199	2
3. Under or (over) accrual (line 2 minus line 1).		\$	(10,266)	3
4. Real Estate Tax accrual used for 2008 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	176,609	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.		\$	166,343	7
Real Estate Tax History:				
Real Estate Tax Bill for Calendar Year:	2003	162,353	8	
	2004	163,747	9	
	2005	165,414	10	
	2006	170,014	11	
	2007	168,199	12	
THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED ON ~105% OF PRIOR YEAR REAL ESTATE TAX BILL				
THE PAYMENT ON LINE 2 APPLIES TO THE 2007 TAX BILL				
	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.

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 46,604 B. General Construction Type: Exterior BRICK Frame BRICK & STEEL Number of Stories 3 & BASEMENT

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: _____ 2. Number of Years Over Which it is Being Amortized: _____
 3. Current Period Amortization: _____ 4. Dates Incurred: _____

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

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	<u>NURSING HOME</u>		<u>2001</u>	<u>\$ 558,037</u>	<u>1</u>
2					<u>2</u>
3	TOTALS			\$ 558,037	3

Facility Name & ID Number LAKEVIEW NURSING & REHABILITATION CENTRE

0026484

Report Period Beginning:

01/01/2008 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	178		2001		\$ 5,022,332	\$ 128,773	39	\$ 128,773	\$	\$ 1,003,545	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	LEASEHOLD IMPROVEMENTS		1982		2,850					2,850	9
10	LEASEHOLD IMPROVEMENTS		1983		2,500		15			2,500	10
11	LEASEHOLD IMPROVEMENTS		1985		2,312		10			2,312	11
12	LEASEHOLD IMPROVEMENTS		1985		3,200		20			3,200	12
13	LEASEHOLD IMPROVEMENTS		1987		29,042	922	20	212	(710)	29,042	13
14	LEASEHOLD IMPROVEMENTS		1987		8,647	275	31.5	275		5,771	14
15	LEASEHOLD IMPROVEMENTS		1988		13,520	429	31.5	429		8,929	15
16	LEASEHOLD IMPROVEMENTS		1989		17,460	554	5		(554)	17,460	16
17	LEASEHOLD IMPROVEMENTS		1989		6,534	207	15		(207)	6,534	17
18	LEASEHOLD IMPROVEMENTS		1990		20,612	654	31.5	654		12,426	18
19	LEASEHOLD IMPROVEMENTS		1991		40,916	1,299	31.5	1,299		22,732	19
20	LEASEHOLD IMPROVEMENTS		1992		40,819	1,296	31.5	1,296		21,452	20
21	LEASEHOLD IMPROVEMENTS		1993		10,482	333	31.5	333		5,273	21
22	LEASEHOLD IMPROVEMENTS		1993		16,965	435	39	435		6,608	22
23	LEASEHOLD IMPROVEMENTS		1994		9,602	246	39	246		3,619	23
24	ROOF REPAIR		1995		3,188	82	39	82		1,112	24
25	SHOWER RECONSTRUCTION		1995		7,775	200	39	200		2,602	25
26	SHOWER ROOMS RENOVATION		1996		35,634	914	39	914		11,509	26
27	OFFICE CONSTRUCTION		1996		4,647	119	39	119		1,481	27
28	ELECTRIC SLIDING DOOR		1996		1,380	35	39	35		426	28
29	BRICKWORK/TUCKPOINT		1997		1,680	43	39	43		503	29
30	PARKING LOT		1997		1,900	49	39	49		672	30
31	CLOSET WORK		1997		800	20	39	20		237	31
32	CONSULTING AND INSTALL FIREDOORS		1997		23,621	606	39	606		6,737	32
33	FIRE ALARM PANEL		1998		3,500	90	39	90		971	33
34	ROOF EXHAUST FANS, INSTALLATION FIRE DAMPTERS		1998		20,698	531	39	531		5,683	34
35	FRONT PORCH ENTRANCE, ONE MARQUEE CANOPY		1998		2,247	57	39	57		604	35
36	SMOKE DAMPERS		1998		1,669	43	39	43		446	36

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

See Page 12A, Line 70 for total

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

Facility Name & ID Number LAKEVIEW NURSING & REHABILITATION CENTRE

0026484

Report Period Beginning:

01/01/2008 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	WALK IN FREEZER-NEW CONDENSING UNIT	1998	\$ 5,546	\$ 142	39	\$ 142		\$ 1,450	37
38	CEILING & LIGHT FIXTURES, ELECTRICAL	1998	30,226	775	39	775		7,784	38
39	CAFETERIAS - 1ST AND 3RD FLOOR	1999	3,000	77	39	77		760	39
40	LIGHTING, ELECTRICAL WORK, INSTALL CABLE	1999	27,482	705	39	705		6,939	40
41	DOORS REPAIR & PAINT-1ST,2ND AND 3RD FLOOR	1999	25,070	643	39	643		6,215	41
42	PLUMBING ROUGH	1999	10,300	264	39	264		2,563	42
43	PAINT WORK-1ST,END,3RD FLOOR, BASEMENT	1999	21,014	539	39	539		5,098	43
44	WALLCOVERING, CARPET TILES	1999	55,627	1,426	39	1,426		13,533	44
45	GENERATOR EXHAUST PIPE	1999	2,300	59	39	59		568	45
46	HANDRAILS-1ST,2ND,3RD FLOOR, BASEMENT	1999	24,340	624	39	624		5,978	46
47	ALARM SYSTEM	1999	107,758	2,763	39	2,763		27,004	47
48	DINING ROOM - 2ND AND 3RD FLOOR	1999	12,206	313	39	313		2,963	48
49	SHOWER AND FRONT STOOP REPAIR	1999	4,300	110	39	110		1,034	49
50	WINDOWS, CLOSETS, EXTERIOR	1999	4,415	113	39	113		978	50
51	INSTALLATION OF THE FIRE DAMPERS	1999	5,880	151	39	151		1,491	51
52	PLEATED SHADES	2000	949		20	47	47	423	52
53	CANVAS CANOPY	2000	3,996	102	39	102		899	53
54	INSTALLATION OF COOLING TOWER	2000	24,450	627	39	627		5,459	54
55	ALARM SYSTEM - ADDITIONAL PROTECTION	2000	1,970	51	39	51		444	55
56	DIALYSIS ROOM EXTRA CIRCUITS	2000	1,983	51	39	51		444	56
57	MICROLIGHT DETECTORS	2000	3,800	97	39	97		825	57
58	REPAIR DRYWALL	2000	3,744	96	39	96		793	58
59	ELECTRICAL PANEL FOR DIALYSIS CENTER	2000	2,380	61	39	61		501	59
60	INSTALLED 9 DOOR HOLDERS	2000	3,465	89	39	89		723	60
61	REMODELING NEW NORTHFIELD OFFICE	2001	3,440	88	39	88		701	61
62	TWO PASSENGER ELEVATOR	2001	84,711	2,172	39	2,172		16,019	62
63	TUCKPOINTING	2001	3,160	81	39	81		584	63
64	REPAVE DRIVEWAY & PARKING LOT	2001	7,000	179	39	179		1,314	64
65	ELECTRICAL WORK	2001	11,922	306	39	306		2,191	65
66	ROOF REPAIR	2001	7,945	204	39	204		1,485	66
67	PAINTING, WALLPAPERING, DRYWALL	2001	42,598	1,092	39	1,092		9,809	67
68	BACKUP GENERATOR	2002	6,375	163	39	163		1,135	68
69	ELECTRICAL WORK	2002	5,000	128	39	128		891	69
70	TOTAL (lines 4 thru 69)		\$ 5,914,884	\$ 152,503		\$ 151,079	\$ (1,424)	\$ 1,316,234	70

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

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 5,914,884	\$ 152,503		\$ 151,079	\$ (1,424)	\$ 1,316,234	1
2	ROOF & GUTTER REPAIR	2002	7,000	180	39	180		1,252	2
3	FLOORING & TILE IN CAFETERIA	2002	5,368	138	20	268	130	1,876	3
4	REPAIR DRIVEWAY & PARKING LOT	2002	3,300	85	15	220	135	1,540	4
5	CABINET INSTALLATION IN MAINTENANCE ROOM	2002	3,200	82	39	82		557	5
6	CARPETING INSTALLATION IN WAITING AREA	2002	3,561	91	20	178	87	1,246	6
7	REPLACE CABLE IN ELEVATOR	2002	5,800	149	39	149		999	7
8	BATHROOM SHOWER	2003	8,075	207	39	207		1,147	8
9	BOILER RE-TUBING	2003	21,850	560	39	560		3,010	9
10	CARPETING AND SHADES	2003	5,186	497	20	259	(238)	1,554	10
11	PLUMBING REVISIONS FOR DIALYSIS LOOP PIPING	2004	14,993	545	27.5	545		2,430	11
12	SPRINKLER SYSTEM & FIRE ALARM REPAIR	2005	6,556	238	27.5	238		863	12
13	ASPHALT PAVEMENT	2006	3,859	257	15	257		771	13
14	SLIDING DOORS & CIRCUIT TO A NEW DOOR OPENER	2006	5,890	214	27.5	214		526	14
15	BUILDING RENOVATION AND REMODELING:	2006	685,986	24,945	27.5	24,945		61,323	15
16	BUIL-IN WARDROBE,WALLCOVERING, TILES, FLOORING,								16
17	1-ST FLOOR LOBBY, DINING ROOM, PHYSICAL THERAPY ROOM,								17
18	NEW CELLINGS, CUSTOM NURSING STATION, BEAUTY SHOP,								18
19	ADMISSION AND ACCOUNTING OFFICE, WALL MOUNTED								19
20	FOUNTAIN, RESIDENT BATHROOM, ACCENT WALL FOR								20
21	CONFERENCE ROOM								21
22									22
23									23
24	735 WEST DIVERSEY BUILDING LLC								24
25	REPLACE 100 TON CHILLER	2007	114,700	11,470	10	11,470			25
26	SEAL COAT ASPHALT RAMP, TUCKPOINTING	2007	10,500	1,050	10	1,050			26
27	INSTALLED TWO OUTDOOR WALL SCONCE,LANTERN	2007	5,243	524	10	524			27
28	INSTALLATION OF ADDT'L SMOKE DETECTOR	2007	3,650	365	10	365			28
29	REPLACE HYDRAULIC CYLINDER FOR ELEVATOR	2007	64,756	6,476	10	6,476			29
30	INSTALL NEW SET OF ROLLER GUIDES ON ELEVATOR	2007	3,169	317	10	317			30
31	DIALYSIS ROOM - FLOORING	2008	3,518	176	10	176			31
32	ELEVATOR-REPLACE DELTA RELAY IN CONTROLLER	2008	2,946	147	10	147			32
33	INSTALL REMOTE ANNUNCIATER	2008	4,033	202	10	202			33
34	TOTAL (lines 1 thru 33)		\$ 6,908,023	\$ 201,418		\$ 200,108	\$ (1,310)	\$ 1,395,328	34

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

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 6,908,023	\$ 201,418		\$ 200,108	\$ (1,310)	\$ 1,395,328	1
2	CHILLER-INSTALL VENTILATION & MONITORING SYSTE	2008	20,223	1,180		1,180			2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 6,928,246	\$ 202,598		\$ 201,288	\$ (1,310)	\$ 1,395,328	34

**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	\$ 964,627	\$ 99,355	\$ 104,364	\$ 5,009	3-15	\$ 398,388	71
72	Current Year Purchases	59,122	11,824	3,201	(8,623)	5-10	3,201	72
73	Fully Depreciated Assets	770,706					770,706	73
74	RELATER PARTY SL DEPRECIATION		56,459	56,459				74
75	TOTALS	\$ 1,794,455	\$ 167,638	\$ 164,024	\$ (3,614)		\$ 1,172,295	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	ADMINISTRATIVE	1999 BLAZER	1999	\$ 34,882	\$ 1,775	\$	\$ (1,775)	5	\$ 34,882	76
77	ADMINISTRATIVE	1999 MERCEDES	2001	53,242	1,775		(1,775)	5	53,242	77
78	ADMINISTRATIVE	2004 LEXUS	2004	43,476	1,675	8,696	7,021	5	43,476	78
79										79
80	TOTALS			\$ 131,600	\$ 5,225	\$ 8,696	\$ 3,471		\$ 131,600	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)	\$ 9,412,338	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 375,461	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 374,008	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (1,453)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 2,699,223	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: N/A - RELATED PARTY

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

If NO, see instructions. YES NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			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: \$ 67,784 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	ADMINISTRATIVE	2009 PORCHE	\$ #####	\$ 15,669	17
18	DON	2005 JEEP CHEROKEE	398.30	4,820	18
19	ADMINISTRATIVE	2004 TOYOTA WAGON	614.52	9,202	19
20					20
21	TOTAL		\$ #####	\$ 29,691	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.	_____	\$ _____
13.	_____	\$ _____
14.	_____	\$ _____

* 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	\$		\$			\$	1	
2	Licensed Speech and Language Development Therapist	39-3	hrs			1,010				1,010	2
3	Licensed Recreational Therapist		hrs								3
4	Licensed Physical Therapist	39-3	hrs			34,918				34,918	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				260,759			260,759	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs								10
11	Academic Education		hrs								11
12	Other (specify):										12
13	Radiology, Respiratory, laboratory Other (specify): <u>Rentals, Dialysis</u>	39-2 39-2					92,297 106,329			92,297 106,329	13
14	TOTAL			\$		\$ 35,928	\$ 459,385		\$	495,313	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 LAKEVIEW NURSING & REHABILITATION CENTRE # 0026484

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	\$ (319,014)	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 100,000)	3,739,517		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	132,241		6
7	Other Prepaid Expenses	5,123		7
8	Accounts Receivable (owners or related parties)	1,222,801		8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 4,780,668	\$	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	1,673,176		15
16	Equipment, at Historical Cost	1,926,054		16
17	Accumulated Depreciation (book methods)	(2,058,121)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			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)	\$ 1,541,109	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 6,321,777	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 1,485,437	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	15,687		28
29	Short-Term Notes Payable	2,412,203		29
30	Accrued Salaries Payable	186,519		30
31	Accrued Taxes Payable (excluding real estate taxes)	9,902		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				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 4,109,748	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	729,739		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)	\$ 729,739	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 4,839,487	\$	46
47	TOTAL EQUITY (page 18, line 24)	\$ 1,482,290	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 6,321,777	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,575,449	1
2	Restatements (describe):		2
3	PRIOR YEAR ADJUSTMENT	(93,757)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,481,692	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	598	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)	\$ 598	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)	\$ 1,482,290	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	\$ 10,223,087	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 10,223,087	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	587,353	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 587,353	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***	34	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 34	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	VENDING COMMISSIONS	1,594	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 1,594	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 10,812,068	30

2

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,669,034	31
32	Health Care	4,391,189	32
33	General Administration	2,736,105	33
	B. Capital Expense		
34	Ownership	1,422,107	34
	C. Ancillary Expense		
35	Special Cost Centers	495,313	35
36	Provider Participation Fee	97,722	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 10,811,470	40
41	Income before Income Taxes (line 30 minus line 40)**	598	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 598	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 LAKEVIEW NURSING & REHABILITATION CENTRE

0026484

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	1,850	2,091	\$ 92,505	\$ 44.24	1
2	Assistant Director of Nursing	2,040	2,356	90,961	38.61	2
3	Registered Nurses	22,102	27,483	771,245	28.06	3
4	Licensed Practical Nurses	38,835	40,618	966,333	23.79	4
5	CNAs & Orderlies	101,083	108,469	1,037,847	9.57	5
6	CNA Trainees					6
7	Licensed Therapist	11,590	12,501	418,777	33.50	7
8	Rehab/Therapy Aides	11,525	12,833	201,523	15.70	8
9	Activity Director	1,963	2,091	30,849	14.75	9
10	Activity Assistants	9,881	10,861	90,813	8.36	10
11	Social Service Workers	5,173	5,740	99,016	17.25	11
12	Dietician					12
13	Food Service Supervisor	1,832	2,092	40,412	19.32	13
14	Head Cook					14
15	Cook Helpers/Assistants	25,450	28,137	301,321	10.71	15
16	Dishwashers					16
17	Maintenance Workers	5,213	5,653	108,945	19.27	17
18	Housekeepers	29,506	31,940	339,651	10.63	18
19	Laundry	7,565	8,289	78,732	9.50	19
20	Administrator	2,940	3,058	185,683	60.72	20
21	Assistant Administrator	1,531	1,930	39,202	20.31	21
22	Other Administrative					22
23	Office Manager	2,001	2,123	80,465	37.90	23
24	Clerical	15,588	16,871	248,768	14.75	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,117	2,168	34,322	15.83	31
32	Other Health Care(specify)	6,494	7,092	127,698	18.01	32
33	Other(specify) <u>MARKETING</u>	4,945	5,352	147,349	27.53	33
34	TOTAL (lines 1 - 33)	311,224	339,748	\$ 5,532,417 *	\$ 16.28	34

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

** See instructions.

B. CONSULTANT SERVICES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference		
35	Dietary Consultant	M	\$ 25,599	1-3	35
36	Medical Director	O	90,000	9-3	36
37	Medical Records Consultant	N	4,320	10-3	37
38	Nurse Consultant	T	0	10-3	38
39	Pharmacist Consultant	H	0	10-3	39
40	Physical Therapy Consultant	L	0	10a-3	40
41	Occupational Therapy Consultant	Y	0	10a-3	41
42	Respiratory Therapy Consultant		0	10a-3	42
43	Speech Therapy Consultant	F	0	10a-3	43
44	Activity Consultant	E	2,444	11-3	44
45	Social Service Consultant	E	1,829	12-3	45
46	Other(specify) <u>Nursing Program</u>	S	30,012	10-3	46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 154,204		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		N/A	10-3	51
52	Certified Nurse Assistants/Aides			10-3	52
53	TOTAL (lines 50 - 52)		\$		53

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	
MICHAEL ELKES	ADMINISTRATOR	0	\$ 143,297	Workers' Compensation Insurance	\$ 156,511	IDPH License Fee	\$	
BARBARA GONZALES	ASST ADMIN	0	39,202	Unemployment Compensation Insurance	51,603	Advertising: Employee Recruitment	38,341	
SAM BOREK	PRESIDENT	50	42,386	FICA Taxes	420,800	Health Care Worker Background Check	5,936	
				Employee Health Insurance	344,255	(Indicate # of checks performed <u>593</u>)		
				Employee Meals	21,521	Patient Background Checks	231	
				Illinois Municipal Retirement Fund (IMRF)*		TRUST/FRANCHISE/CONTRIB/ETC	10,836	
				EMPLOYEE BENEFITS - OTHER	12,046	MARKETING/ADV/PROMO	63,397	
				EMPLOYEE PHYSICAL EXAMS	0	LICENSES/DUES/SUBSCRIPTIONS	19,614	
				PENSION/PROFIT SHARING PLANS	37,348	MGMT CO ALLOC	1,944	
				CHICAGO HEAD TAX	8,600	TRUST/FRANCHISE/CONTRIB/ETC	(10,836)	
				INSURANCE - EXECUTIVE LIFE	0	Less: Public Relations Expense	(57,955)	
				INSURANCE - EXECUTIVE LIFE VI 21	0	Non-allowable advertising	(827)	
						Yellow page advertising	(4,615)	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 224,885	TOTAL (agree to Schedule V, line 22, col.8)		TOTAL (agree to Sch. V, line 20, col. 8)		
				\$ 1,052,684		\$ 68,149		
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Description			Amount	Description	Line #	Amount	Description	Amount
CONSULTANTS FOR CORPORATE MANAGEMENT			\$ 385,000			\$	Out-of-State Travel	\$
							In-State Travel	0
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 385,000				Seminar Expense	8,492
							Entertainment Expense	()
							(agree to Sch. V, line 24, col. 8)	
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 118,264	TOTAL		\$	TOTAL	\$ 8,492

* Attach copy of IMRF notifications

**See instructions.

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

(See instructions.)

1	2	3	4	5	6	7	8	9	10	11	12	13
Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	FY2005	FY2006	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013
1		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2	PAINT/DECORATING	2006	2,930	3 YRS		489	976	976	489			
3												
4												
5												
6												
7												
8												
9												
10												
11												
12												
13												
14												
15												
16												
17												
18												
19												
20	TOTALS		\$ 2,930		\$	\$ 489	\$ 976	\$ 976	\$ 489	\$	\$	\$

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? YES
- (2) Are there any dues to nursing home associations included on the cost report? YES
If YES, give association name and amount. IL COUNCIL ON LONG TERM CARE \$7,340
- (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. \$ 516 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. \$ 97,722
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. \$ 21,521 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