

Facility Name & ID Number Parkview Terrace

0045294 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 N/A

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>24</u>	Skilled (SNF)	<u>24</u>	<u>8,784</u>	1
2		Skilled Pediatric (SNF/PED)			2
3	<u>96</u>	Intermediate (ICF)	<u>96</u>	<u>35,136</u>	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>120</u>	TOTALS	<u>120</u>	<u>43,920</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	<u>95</u>	<u>301</u>	<u>3,050</u>	<u>3,446</u>	8
9	SNF/PED					9
10	ICF	<u>20,426</u>	<u>2,356</u>	<u>4,603</u>	<u>27,385</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>20,521</u>	<u>2,657</u>	<u>7,653</u>	<u>30,831</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 70.20%

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 Note: Non-allowable costs have been eliminated in Schedule V, Column 7.

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

I. On what date did you start providing long term care at this location?
Date started 02/02/2001

J. Was the facility purchased or leased after January 1, 1978?
YES Date 01/01/2001 NO

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 24 and days of care provided 2,467

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRAUAL MODIFIED CASH* CASH*

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

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

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

Facility Name & ID Number Parkview Terrace # 0045294 Report Period Beginning: 01/01/2008 Ending: 12/31/2008

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7**	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	158,184	16,553	4,630	179,367		179,367		179,367		1
2	Food Purchase		151,084		151,084		151,084		151,084		2
3	Housekeeping	112,054	16,403		128,457		128,457		128,457		3
4	Laundry	49,543	13,492		63,035		63,035		63,035		4
5	Heat and Other Utilities			122,990	122,990		122,990	564	123,554		5
6	Maintenance	75,279	4,393	35,316	114,988		114,988		114,988		6
7	Other (specify):*										7
8	TOTAL General Services	395,060	201,925	162,936	759,921		759,921	564	760,485		8
	B. Health Care and Programs										
9	Medical Director			17,032	17,032		17,032		17,032		9
10	Nursing and Medical Records	1,170,736	48,990	1,110	1,220,836		1,220,836	210	1,221,046		10
10a	Therapy	49,475		223,520	272,995		272,995		272,995		10a
11	Activities	66,349	5,370	1,358	73,077		73,077		73,077		11
12	Social Services	48,106		1,163	49,269		49,269		49,269		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,334,666	54,360	244,183	1,633,209		1,633,209	210	1,633,419		16
	C. General Administration										
17	Administrative	129,525		201,514	331,039		331,039	(201,514)	129,525		17
18	Directors Fees										18
19	Professional Services			88,631	88,631		88,631	(22,221)	66,410		19
20	Dues, Fees, Subscriptions & Promotions			22,693	22,693		22,693	944	23,637		20
21	Clerical & General Office Expenses	148,921	17,824	49,886	216,631		216,631	6,062	222,693		21
22	Employee Benefits & Payroll Taxes			278,390	278,390		278,390		278,390		22
23	Inservice Training & Education			729	729		729	1,343	2,072		23
24	Travel and Seminar			1,933	1,933		1,933	8,801	10,734		24
25	Other Admin. Staff Transportation			62,395	62,395		62,395	2,453	64,848		25
26	Insurance-Prop.Liab.Malpractice			70,124	70,124		70,124	1,154	71,278		26
27	Other (specify):* Home Office Benefits							36,558	36,558		27
28	TOTAL General Administration	278,446	17,824	776,295	1,072,565		1,072,565	(166,420)	906,145		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,008,172	274,109	1,183,414	3,465,695		3,465,695	(165,646)	3,300,049		29

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number

Parkview Terrace

#0045294

Report Period Beginning:

01/01/2008

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			10,995	10,995		10,995	129,238	140,233			30
31	Amortization of Pre-Op. & Org.							9,267	9,267			31
32	Interest			92,534	92,534		92,534	251,979	344,513			32
33	Real Estate Taxes			83,064	83,064		83,064		83,064			33
34	Rent-Facility & Grounds			504,000	504,000		504,000	(497,400)	6,600			34
35	Rent-Equipment & Vehicles			20,064	20,064		20,064	1,752	21,816			35
36	Other (specify):*											36
37	TOTAL Ownership			710,657	710,657		710,657	(105,164)	605,493			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		124,703		124,703		124,703		124,703			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			65,880	65,880		65,880		65,880			42
43	Other (specify):* Non-allowable cost	14,763	5,368	83,193	103,324		103,324	(103,324)				43
44	TOTAL Special Cost Centers	14,763	130,071	149,073	293,907		293,907	(103,324)	190,583			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,022,935	404,180	2,043,144	4,470,259		4,470,259	(374,134)	4,096,125			45

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

**See schedule of adjustments attached at end of cost report.

SEE ACCOUNTANTS' COMPILATION REPORT

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	(39,786)	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(63,129)	43		24
25	Fund Raising, Advertising and Promotional	(24,314)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule <u>See Page 5A</u>	(42,147)	Vari.		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (169,376)		\$	30

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)	(204,758)	Vari.	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (204,758)		36
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (374,134)		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		x			45
46	Other-Attach Schedule		x			46
47	TOTAL (C): (sum of lines 38-46)			\$		47

BHF USE ONLY							
48		49		50		51	
							52

Parkview Terrace

ID# 0045294

Report Period Beginning: 01/01/2008

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NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	Non-allowable Lab Expense	\$ (9,056)	43	1
2	Non-Allowable X-Ray Expense	(6,823)	43	2
3	Disallow non-allowable legal retainer	(10,000)	19	3
4	Offset Other Income	(236)	21	4
5	Disallow non-allowable legal out-of-period	(15,842)	19	5
6	Disallow Marketing Seminar	(190)	24	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	(42,147)		49

SEE ACCOUNTANTS' COMPILATION REPORT

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
Suzanne Koenig	51	See Attached		SAK Management		
Melvin Siegel	49	See Attached		Management Svcs	Chicago	Management Co.
				Parkview Terrace		
				Properties, LLC	Skokie	Building Company
				Mavin Enterprises		
				LTD	Skokie	Bookkeeping

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization			
1	V	30 Depreciation	\$	Parkview Terrace Properties, LLC	100.00%	\$ 167,786	\$	167,786	1
2	V	31 Amortization		Parkview Terrace Properties, LLC	100.00%	9,267		9,267	2
3	V	32 Interest		Parkview Terrace Properties, LLC	100.00%	251,978		251,978	3
4	V	34 Rent - Facility & Grounds	504,000		100.00%			(504,000)	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		\$ 504,000			\$ 429,031	\$ *	(74,969)	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	5 Utilities	\$	SAK Management Services, LLC	51.00%	\$ 564	\$	564	15
16	V	10 Nursing		SAK Management Services, LLC	51.00%	210		210	16
17	V	17 Administrative	201,514	SAK Management Services, LLC	51.00%			(201,514)	17
18	V	19 Professional Services		SAK Management Services, LLC	51.00%	3,621		3,621	18
19	V	20 Dues, Fees & Subscriptions		SAK Management Services, LLC	51.00%	944		944	19
20	V	21 Clerical & General		SAK Management Services, LLC	51.00%	6,298		6,298	20
21	V	23 Inservice Training & Education		SAK Management Services, LLC	51.00%	1,343		1,343	21
22	V	24 Travel & Seminar		SAK Management Services, LLC	51.00%	8,991		8,991	22
23	V	25 Other Admin. Staff Transportation		SAK Management Services, LLC	51.00%	921		921	23
24	V	26 Insurance - Property & Liability		SAK Management Services, LLC	51.00%	1,154		1,154	24
25	V	27 Employee Benefits - Mgmt. Co.		SAK Management Services, LLC	51.00%	36,558		36,558	25
26	V	30 Depreciation		SAK Management Services, LLC	51.00%	1,237		1,237	26
27	V	34 Rent - Facility & Grounds		SAK Management Services, LLC	51.00%	6,600		6,600	27
28	V	35 Rent - Eqpt. & Vehicles		SAK Management Services, LLC	51.00%	1,752		1,752	28
29	V								29
30	V								30
31	V								31
32	V	25 Travel & Seminar		SAK Management Services, LLC	51.00%	1,532		1,532	32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total		\$ 201,514			\$ 71,725	\$ *	(129,789)	39

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

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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	N/A								\$	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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Parkview Terrace

0045294

Report Period Beginning:

01/01/2008

Ending: 2/31/2008

VIII. ALLOCATION OF INDIRECT COSTS

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

Name of Related Organization SAK Management Services, LLC
 Street Address 4055 W. Peterson, Suite 101
 City / State / Zip Code Chicago, IL 60646
 Phone Number (773) 202-0000
 Fax Number (773) 267-0111

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	5	Utilities	SAK Mgmt. Fees	1,915,081	8	\$ 5,361	\$ 201,514	\$ 564	1
2	10	Nursing	SAK Mgmt. Fees	1,915,081	8	1,998	201,514	210	2
3	19	Professional Services	SAK Mgmt. Fees	1,915,081	8	34,415	201,514	3,621	3
4	20	Dues, Fees & Subscriptions	SAK Mgmt. Fees	1,915,081	8	8,974	201,514	944	4
5	21	Clerical & General	SAK Mgmt. Fees	1,915,081	8	59,856	201,514	6,298	5
6	23	Inservice Training & Education	SAK Mgmt. Fees	1,915,081	8	12,762	201,514	1,343	6
7	24	Travel & Seminar	SAK Mgmt. Fees	1,915,081	8	85,442	201,514	8,991	7
8	25	Other Admin. Staff Transportation	SAK Mgmt. Fees	1,915,081	8	8,757	201,514	921	8
9	26	Insurance - Property & Liability	SAK Mgmt. Fees	1,915,081	8	10,969	201,514	1,154	9
10	27	Employee Benefits - Mgmt. Co.	SAK Mgmt. Fees	1,915,081	8	347,424	201,514	36,558	10
11	30	Depreciation	SAK Mgmt. Fees	1,915,081	8	11,758	201,514	1,237	11
12	34	Rent - Facility & Grounds	SAK Mgmt. Fees	1,915,081	8	62,727	201,514	6,600	12
13	35	Rent - Eqpt. & Vehicles	SAK Mgmt. Fees	1,915,081	8	16,653	201,514	1,752	13
14									14
15									15
16	24	Travel & Seminar	Direct Cost	1		1,532	1	1,532	16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 668,628	\$	\$ 71,725	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number

Parkview Terrace

0045294

Report Period Beginning:

01/01/2008

Ending:

12/31/2008

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	Name of Lender	2		3	4	5	6		7	8	9	10						
		Related**					Purpose of Loan	Monthly Payment Required					Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO											Original	Balance			
A. Directly Facility Related																		
Long-Term																		
1	Cole Taylor Bank		X	Mortgage	\$31,199.84	04/2005	\$ 3,345,468	\$ 3,136,864	04/2008	0.0600	\$ 196,054	1						
2	Cole Taylor Bank		X	Construction Loan	\$4,317.52	01/2007	602,470	567,785	04/2008	0.0600	39,808	2						
3	East Moline Garden Plaza		X	Jr. Mortgage	Variable	04/2005	350,000	168,528	05/2008	0.0600	16,117	3						
4												4						
5												5						
Working Capital																		
6	Suzanne Koenig	X		Business Loan	Variable	07/2007	251,628	316,314	On Demand	0.1200	29,566	6						
7	Cole Taylor Bank		X	Line of Credit	Variable	04/2005	364,633	988,173	04/2008	Prime + 1	62,968	7						
8												8						
9	TOTAL Facility Related				\$35,517.36		\$ 4,914,199	\$ 5,177,664			\$ 344,513	9						
B. Non-Facility Related*																		
10												10						
11												11						
12												12						
13												13						
14	TOTAL Non-Facility Related						\$	\$			\$	14						
15	TOTALS (line 9+line14)						\$ 4,914,199	\$ 5,177,664			\$ 344,513	15						

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ No Line # N/A

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

(See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

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

(See instructions.)

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, please call the Bureau of Health Finance at (217) 782-1630.

2007 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Parkview Terrace COUNTY Rock Island

FACILITY IDPH LICENSE NUMBER 0045294

CONTACT PERSON REGARDING THIS REPORT Suzanne Koenig

TELEPHONE (773) 202-000 FAX #: (773) 267-0111

A. Summary of Real Estate Tax Cost

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. <u>07-514-20-000</u>	<u>Nursing Home</u>	\$ <u>83,728.48</u>	\$ <u>83,728.48</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>83,728.48</u>	\$ <u>83,728.48</u>

B. Real Estate Tax Cost Allocations

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

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

C. Tax Bills

Attach a copy of the original 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.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Parkview Terrace

0045294

Report Period Beginning:

01/01/2008 Ending:

12/31/2008

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 27,040 B. General Construction Type: Exterior Brick Frame _____ Number of Stories _____

C. Does the Operating Entity? (a) Own the Facility (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? (a) Own the Equipment (b) Rent equipment from a Related Organization. (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.)

List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

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

1. Total Amount Incurred: 111,210 2. Number of Years Over Which it is Being Amortized: 5

3. Current Period Amortization: 9,267 4. Dates Incurred: _____

Nature of Costs:

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

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>Facility</u>			\$ <u>334,546</u>	1
2					2
3	TOTALS			\$ 334,546	3

SEE ACCOUNTANTS' COMPILATION REPORT

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	120	2005		\$ 2,770,922	\$	27.5	\$ 100,751	\$ 100,751	\$ 373,635	4
5										5
6										6
7										7
8										8
Improvement Type**										
9	A-WING PAINTING & REFURBISHING OF RESIDENT ROOMS		2002	6,000		5			6,000	9
10	PAINTING & DECORATING		2003	30,000		5			30,000	10
11	INSTALL ALARM SYSTEM		2004	5,451		27.5	198	198	833	11
12										12
13	Sprinkler Repairs		2007	12,934		27.5	470	470	705	13
14	Construction of Additional Office & Therapy Space		2007	518,672		27.5	18,861	18,861	36,936	14
15	- general construction, electrical, drywall, HVAC, plumbing									15
16	painting									16
17										17
18	Repair for Broken Pipe - Ceiling & Sprinklers		2008	5,581		20	140	140	140	18
19	Call Lighting System		2008	21,874		20	547	547	547	19
20	West Side of Roof Replaced		2008	5,850		20	146	146	146	20
21	Replace Back Porch with Wall and Walkway		2008	6,970		20	174	174	174	21
22			2008	10,458		20	261	261	261	22
23										23
24										24
25	Current Booked Depreciation Expense				10,995			(10,995)		25
26										26
27										27
28										28
29										29
30										30
31										31
32										32
33										33
34										34
35										35
36										36

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

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

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9					
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation					
37		\$	\$		\$	\$	\$	37				
38								38				
39								39				
40								40				
41								41				
42								42				
43								43				
44								44				
45								45				
46								46				
47								47				
48								48				
49								49				
50								50				
51								51				
52								52				
53								53				
54								54				
55								55				
56								56				
57								57				
58								58				
59								59				
60								60				
61								61				
62								62				
63								63				
64								64				
65								65				
66								66				
67								67				
68								68				
69								69				
70	TOTAL (lines 4 thru 69)	\$	3,394,712	\$	10,995	\$	121,548	\$	110,553	\$	449,377	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Parkview Terrace

0045294

Report Period Beginning:

01/01/2008

Ending:

12/31/2008

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	\$ 15,763	\$	\$ 1,577	\$ 1,577	10	\$ 8,413	71
72	Current Year Purchases	1,011		169	169	3	169	72
73	Fully Depreciated Assets							73
74	Allocation from RE Entity & SAK Mgmt.	240,000		9,758	9,758		59,322	74
75	TOTALS	\$ 256,774	\$	\$ 11,504	\$ 11,504		\$ 67,904	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	Facility	1998 Ford Windstar	2004	\$ 16,050	\$	\$ 3,210	\$ 3,210	5	\$ 16,050	76
77	Administrative	2001 Lexus	2004	19,856		3,971	3,971	5	19,855	77
78										78
79										79
80	TOTALS			\$ 35,906	\$	\$ 7,181	\$ 7,181		\$ 35,905	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)	\$ 4,021,938	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 10,995	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 140,233	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 129,238	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 553,186	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	N/A	\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92	N/A	\$	92
93			93
94			94
95		\$	95

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

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

If NO, see instructions. YES NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$ _____			3
4	Additions							4
5								5
6		Allocated from SAK Mgmt.			6,600			6
7	TOTAL				\$ 6,600			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: \$ 21,816 Description: H2O Sftnr 254; Dish Mchn 893; Laundry 8316; Off Eqp 6845; Nsg Eqpt 3627; SAK Alloc. 1752; Air Tnk 129

(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			N/A		18
19					19
20					20
21	TOTAL		\$ _____	\$ _____	21

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

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

Fiscal Year Ending Annual Rent

12. _____ /2009 \$ _____

13. _____ /2010 \$ _____

14. _____ /2011 \$ _____

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

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

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility		3	4
		1	2		
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	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.
- SEE ACCOUNTANTS' COMPILATION REPORT**

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	10A(3)	hrs	\$	1,600	\$ 96,028	\$	1,600	\$ 96,028	1
2	Licensed Speech and Language Development Therapist	10A(3)	hrs		78	4,695		78	4,695	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A(3)	hrs		2,047	122,797		2,047	122,797	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				107,959		107,959	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): <u>Oxygen</u>	39(2)					16,744		16,744	12
13	Other (specify): _____									13
14	TOTAL			\$	3,725	\$ 223,520	\$ 124,703	3,725	\$ 348,223	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Parkview Terrace

0045294

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	\$ 100	\$ 100	1
2	Cash-Patient Deposits	24,723	24,723	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance -0-)	1,451,665	1,451,665	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	143,055	143,055	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Schedule 17A	489,914	968,101	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,109,457	\$ 2,587,644	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		334,546	13
14	Buildings, at Historical Cost	34,694	2,805,616	14
15	Leasehold Improvements, at Historical Cost	59,966	589,096	15
16	Equipment, at Historical Cost	63,138	292,680	16
17	Accumulated Depreciation (book methods)	(89,716)	(553,186)	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)	\$ 68,082	\$ 3,468,752	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,177,539	\$ 6,056,396	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 1,299,088	\$ 1,299,088	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	24,723	24,723	28
29	Short-Term Notes Payable	988,173	988,173	29
30	Accrued Salaries Payable	103,824	103,824	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	92,731	92,731	32
33	Accrued Interest Payable	20,466	43,921	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Payroll Liabilities	165,406	165,406	36
37	See Schedule 17A	520,635	520,635	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 3,215,046	\$ 3,238,501	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	316,314	484,842	39
40	Mortgage Payable		3,704,649	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)	\$ 316,314	\$ 4,189,491	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 3,531,360	\$ 7,427,992	46
47	TOTAL EQUITY(page 18, line 24)	\$ (1,353,821)	\$ (1,371,596)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,177,539	\$ 6,056,396	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

Parkview Terrace, LLC
Provider #: 0045294
1/1/2008 to 12/31/2008

Schedule 17A

XV. Balance Sheet

	<u>Operating</u>	<u>After Consolidation</u>
Line 9 - Other (specify)		
Medicare PIP	25,621	25,621
Due From Related Parties	464,293	942,480
	<u>489,914</u>	<u>968,101</u>
Line 37 - Other Current Liabilities (specify)		
Due To Related Parties	380,307	380,307
Cost Report Settlement Liability	140,328	140,328
Total Line 37 - Other Current Liabilities	<u>520,635</u>	<u>520,635</u>

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (913,840)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (913,840)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(439,981)	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)	\$ (439,981)	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)	\$ (1,353,821)	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

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	\$ 3,373,806	1
2	Discounts and Allowances for all Levels	9,610	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,383,416	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	534,290	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 534,290	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	112,336	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)	\$ 112,336	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Other Revenue</u>	236	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 236	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 4,030,278	30

2

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	759,921	31
32	Health Care	1,633,209	32
33	General Administration	1,072,565	33
	B. Capital Expense		
34	Ownership	710,657	34
	C. Ancillary Expense		
35	Special Cost Centers	228,027	35
36	Provider Participation Fee	65,880	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 4,470,259	40
41	Income before Income Taxes (line 30 minus line 40)**	(439,981)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (439,981)	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.
Entity is a cash basis taxpayer

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

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

Facility Name & ID Number Parkview Terrace

0045294

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	2,107	2,397	\$ 67,233	\$ 28.05	1
2	Assistant Director of Nursing	1,995	2,125	43,074	20.27	2
3	Registered Nurses	3,257	3,445	68,608	19.92	3
4	Licensed Practical Nurses	21,008	22,051	371,217	16.83	4
5	CNAs & Orderlies	52,491	54,689	560,719	10.25	5
6	CNA Trainees	0	0			6
7	Licensed Therapist	0	0			7
8	Rehab/Therapy Aides	3,194	3,555	49,475	13.92	8
9	Activity Director	0	0			9
10	Activity Assistants	6,073	6,424	66,349	10.33	10
11	Social Service Workers	3,642	3,906	48,106	12.32	11
12	Dietician	0	0			12
13	Food Service Supervisor	0	0	0		13
14	Head Cook	0	0	0		14
15	Cook Helpers/Assistants	13,446	14,168	158,184	11.17	15
16	Dishwashers	0	0			16
17	Maintenance Workers	4,029	4,343	75,279	17.34	17
18	Housekeepers	12,482	13,327	112,054	8.41	18
19	Laundry	3,856	4,268	49,543	11.61	19
20	Administrator	928	960	54,941	57.23	20
21	Assistant Administrator	96	120	7,617	63.47	21
22	Other Administrative	1,072	1,240	66,967	54.01	22
23	Office Manager					23
24	Clerical	8,721	9,393	148,921	15.85	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator	1,983	2,104	38,292	18.20	29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,920	2,000	21,593	10.80	31
32	Other Health Care(specify)					32
33	Other(specify) <u>Marketing</u>	1,064	1,120	14,763	13.18	33
34	TOTAL (lines 1 - 33)	143,361	151,633	\$ 2,022,935 *	\$ 13.34	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	Monthly	\$ 4,630	1(3)	35
36	Medical Director	Monthly	17,032	9(3)	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	850	10(3)	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	Monthly	1,358	11(3)	44
45	Social Service Consultant	Monthly	1,163	12(3)	45
46	Other(specify) <u>Nurse Rehab. Cons.</u>	Monthly	260	10(3)	46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 25,293		49

C. CONTRACT NURSES

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number **Parkview Terrace**

0045294

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

Ending: **12/31/2008**

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		
ROBERT TALBOT	Administrator	0	\$ 54,941	Workers' Compensation Insurance	\$ 44,202	IDPH License Fee	\$		
SHELLY DOTHAGER	Admin. Assist	0	7,617	Unemployment Compensation Insurance	36,957	Advertising: Employee Recruitment	7,673		
ROBIN LEMASTERS	Admin Consult.	0	66,967	FICA Taxes	154,495	Health Care Worker Background Check (Indicate # of checks performed <u>158</u>)	1,900		
				Employee Health Insurance	39,332	Patient Background Checks	1,370		
				Employee Meals		IL Council on Long Term Care	8,904		
				Illinois Municipal Retirement Fund (IMRF)*		CLIA	515		
				Employee Morale	3,404	Miscellaneous Licenses & Permits	2,331		
						Allocation from SAK Mgmt. Svcs.	944		
						Less: Public Relations Expense	()		
						Non-allowable advertising	()		
						Yellow page advertising	()		
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 129,525	TOTAL (agree to Schedule V, line 22, col.8)		\$ 23,637			
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	
SAK Management Services, LLC (Eliminated in Column 7)			\$ 201,514	N/A		\$	Out-of-State Travel	\$	
							In-State Travel		
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 201,514				Seminar Expense	1,743	
C. Professional Services							Allocation from SAK Mgmt. Svcs.		8,991
Vendor/Payee	Type		Amount				Entertainment Expense		()
See Schedule 21A	Various		\$ 88,631				TOTAL (agree to Sch. V, line 24, col. 8)		\$ 10,734
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 88,631	TOTAL					

* Attach copy of IMRF notifications
SEE ACCOUNTANTS' COMPILATION REPORT

**See instructions.

Parkview Terrace
 Facility ID#: 0045294
 12/31/2008

Schedule 21A

Schedule XIX (C) - Professional Fees.

Vendor	Services	Amount
Aronberg Goldgehn Davis & Garmisa	Legal	238
Jeffrey Steinback-Attorney	Legal	5,000
Lawrence S. Beaumont	Legal	5,000
Morris.Anderson & Assoc. Ltd	Legal	15,842
Shaw Gussis Fishman Glantz Wolfson	Legal	21,982
Stahl Cowen Crowley LLC.	Legal	1,307
Winstein, Kavensky & Wallace	Legal	9,720
Alpha Data Services, LLC	Payroll/Year End	814
HDSI - Health Data Systems, Inc.	A/R system service	5,514
LTC Solutions Inc.	Software Consulting	1,500
PAYDAY-USA	Payroll Processing Service	3,219
RSM McGladry, Inc	Cost Reports	10,145
FR&R	Reimbursement	110
Personnel Planners, Inc	Consulting	360
RSM McGladrey, Inc.	Taxes	4,250
Sharon Lofgren	Medicare billing & consultin	3,000
Walnut Grove Village, LLC	Consulting	630
TOTAL (agree to Schedule V, line 19, column 3)		88,631
Less: Disallowed non-allowable legal fees		(25,842)
Allocation from SAK - Legal		1,022
Allocation from SAK - Data Processing		1,096
Allocation from SAK - Other Consulting		744
Allocation from SAK - Computer Tech		760
TOTAL (agree to Schedule V, line 19, column 8)		66,410

SEE ACCOUNTANTS' COMPILATION REPORT

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

(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2005	FY2006	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013
1			\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4		N/A											
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Parkview Terrace# 0045294Report Period Beginning: 01/01/2008Ending: 12/31/2008**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? Yes
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. IL Council on Long Term Care - \$8,904
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? 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? 3
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 0 Line 10(2)
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? 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. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 65,880
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.

SEE ACCOUNTANTS' COMPILATION REPORT

- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? No Indicate the amount. \$ N/A
- (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? Adequate records have been maintained.
- e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
- f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
- g. Does the facility transport residents to and from day training? No**
Indicate the amount of income earned from providing such transportation during this reporting period. \$ 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? N/A If no, please explain. N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? Yes
Attach invoices and a summary of services for all architect and appraisal fees