



Facility Name & ID Number SOUTHVIEW MANOR

# 0048421 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	74	Skilled (SNF)	74	27,084	1
2		Skilled Pediatric (SNF/PED)			2
3	126	Intermediate (ICF)	126	46,116	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	200	TOTALS	200	73,200	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	4,494		4,516	9,010	8
9	SNF/PED					9
10	ICF	61,595	440	461	62,496	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	66,089	440	4,977	71,506	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 97.69%

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 11/01/06

J. Was the facility purchased or leased after January 1, 1978?  
YES  Date 11/01/06 NO

K. Was the facility certified for Medicare during the reporting year?  
YES  NO  If YES, enter number of beds certified 42 and days of care provided 4,516

Medicare Intermediary ADMINISTAR FEDERAL

IV. ACCOUNTING BASIS

ACCRAUAL  MODIFIED CASH\*  CASH\*

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

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

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

Facility Name & ID Number SOUTHVIEW MANOR # 0048421 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
	<b>A. General Services</b>										
1	Dietary	230,768	31,615	12,621	275,004		275,004		275,004		1
2	Food Purchase		322,729		322,729		322,729	(1,616)	321,113		2
3	Housekeeping	316,801	43,005		359,806		359,806		359,806		3
4	Laundry	58,266	17,152	4,913	80,331		80,331	1,622	81,953		4
5	Heat and Other Utilities			194,233	194,233		194,233		194,233		5
6	Maintenance	186,185	71,616	72,514	330,315		330,315	5,275	335,590		6
7	Other (specify):* SECURITY	170,073		19,629	189,702		189,702	72	189,774		7
8	<b>TOTAL General Services</b>	<b>962,093</b>	<b>486,117</b>	<b>303,910</b>	<b>1,752,120</b>		<b>1,752,120</b>	<b>5,353</b>	<b>1,757,473</b>		<b>8</b>
	<b>B. Health Care and Programs</b>										
9	Medical Director			6,700	6,700		6,700		6,700		9
10	Nursing and Medical Records	1,942,442	76,412	17,410	2,036,264		2,036,264		2,036,264		10
10a	Therapy	21,936		660	22,596		22,596		22,596		10a
11	Activities	101,482	15,962	1,958	119,402		119,402		119,402		11
12	Social Services	177,418		3,164	180,582		180,582		180,582		12
13	CNA Training										13
14	Program Transportation			468	468		468		468		14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	<b>2,243,278</b>	<b>92,374</b>	<b>30,360</b>	<b>2,366,012</b>		<b>2,366,012</b>		<b>2,366,012</b>		<b>16</b>
	<b>C. General Administration</b>										
17	Administrative	160,395		296,712	457,107		457,107	(95,770)	361,337		17
18	Directors Fees										18
19	Professional Services			70,832	70,832		70,832	10,277	81,109		19
20	Dues, Fees, Subscriptions & Promotions			27,794	27,794		27,794	(8,434)	19,360		20
21	Clerical & General Office Expenses	166,770	34,961	80,852	282,583		282,583	(34,733)	247,850		21
22	Employee Benefits & Payroll Taxes			655,878	655,878		655,878		655,878		22
23	Inservice Training & Education							8	8		23
24	Travel and Seminar			1,712	1,712		1,712		1,712		24
25	Other Admin. Staff Transportation			3,980	3,980		3,980	1,162	5,142		25
26	Insurance-Prop.Liab.Malpractice			99,133	99,133		99,133	1,147	100,280		26
27	Other (specify):*			254,953	254,953		254,953	(239,596)	15,357		27
28	<b>TOTAL General Administration</b>	<b>327,165</b>	<b>34,961</b>	<b>1,491,846</b>	<b>1,853,972</b>		<b>1,853,972</b>	<b>(365,939)</b>	<b>1,488,033</b>		<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	<b>3,532,536</b>	<b>613,452</b>	<b>1,826,116</b>	<b>5,972,104</b>		<b>5,972,104</b>	<b>(360,586)</b>	<b>5,611,518</b>		<b>29</b>

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

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
<b>1</b>	<b>DIETARY</b>	
	DIETITIAN CONSULTANT XVIII B 35-2	12,621
	REPAIRS & MAINTENANCE	0
		0
		12,621
<b>3</b>	<b>HOUSEKEEPING</b>	
		0
		0
		0
<b>4</b>	<b>LAUNDRY</b>	
	EQUIPMENT REPAIRS & MAINTENANCE	4,913
		0
		4,913
<b>5</b>	<b>HEAT &amp; OTHER UTILITIES</b>	
	GAS HEAT	103,203
	ELECTRICITY	71,715
	WATER	19,315
	CABLE TV - LOBBY	0
		0
		194,233
<b>6</b>	<b>MAINTENANCE</b>	
	GROUNDS MAINTENANCE	450
	PAINTING & DECORATING	1,260
	BUILDING REPAIRS	0
	MAINTENANCE TRAVEL	0
	EQUIPMENT MAINTENANCE & REPAIR	20,068
	ELEVATOR MAINTENANCE & REPAIR	30,805
	OUTSIDE LABOR	0
	EXTERMINATING SERVICE	3,565
	FIRE SERVICE	16,366
		0
		0
		0
		0
		72,514
<b>7</b>	<b>OTHER</b>	
	SCAVENGER	19,629
	SECURITY SERVICE	0
		0
		0
		19,629
<b>9</b>	<b>MEDICAL DIRECTOR</b>	
	MEDICAL DIRECTOR FEES XVIII B 36-2	6,700
		6,700

LINE	SCHED REF	TOTAL
<b>10</b>	<b>NURSING</b>	
	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	1,870
	PHARMACY CONSULTANT XVIII B 39-2	5,940
	UTILIZATION REVIEW FEES XVIII B ___-2	0
	PHYSICIANS XVIII B ___-2	0
	PSYCHIATRIC XVIII B ___-2	4,800
	RN CONSULTANT XVIII B 38-2	0
	DENTAL	4,800
		0
		17,410
<b>10a</b>	<b>THERAPY</b>	
	PHYSICAL THERAPY SERVICES	
	SPEECH THERAPY SERVICES	54
	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	606
	RESPIRATORY THERAPY CONSULTAN XVIII B 42-2	0
	SPEECH THERAPY CONSULTANT XVIII B 43-2	0
		660
<b>11</b>	<b>ACTIVITIES</b>	
	CABLE TV - PATIENT ROOMS	
	ACTIVITY REHAB CONSULTANT XVIII B 44-2	1,958
		0
		1,958
<b>12</b>	<b>SOCIAL SERVICES</b>	
	SOCIAL REHABILITATION SERVICES	
	SOCIAL REHABILITATION CONSULTAN XVIII B 45-2	0
	SOCIAL WORKER XVIII B 45-2	3,164
		0
		3,164
<b>13</b>	<b>NURSE AIDE TRAINING</b>	
	NURSE AIDE TRAINING COSTS XIII	0
		0

V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE	SCHED REF	TOTAL
14	<b>PROGRAM TRANSPORTATION</b>	
	PATIENT TRANSPORTATION	468
17	<b>ADMINISTRATIVE</b>	
	MANAGEMENT FEES XIX B	296,712
	<b>DIRECTORS FEES</b>	
18	DIRECTORS FEES	0
19	<b>PROFESSIONAL SERVICES</b>	
	DATA PROCESSING XIX C	20,136
	ADMINISTRATIVE CONSULTANTS XIX C	23,285
	PROFESSIONAL FEES XIX C	27,411
		0
		70,832
20	<b>FEES,SUBSCRIPTIONS,PROMOTIONS</b>	
	ENTERTAINMENT & MARKETING VI 19 XIX F	0
	ADV & PROMO-NON PATIENT RELATED VI 25 XIX F	2,604
	EMPLOYEE WANT ADS XIX F	0
	CONTRIBUTIONS VI 20 XIX F	0
	DUES & SUBSCRIPTIONS XIX F	7,475
	LICENSES & PERMITS XIX F	9,237
	PUBLIC RELATIONS-PATIENT RELATED XIX F	0
	ADVERTISING-YELLOW PAGES VI 28 XIX F	0
	TRUST FEES / FRANCHISE TAX / ETC VI 17 XIX F	0
	CONTRIBUTIONS - POLITICAL VI 20 XIX F	8,438
	HEALTH CARE WORKER BACKGROUND CHEC XIX F	40
	PATIENT BACKGROUND CHECKS XIX F	0
		27,794
21	<b>CLERICAL &amp; GENERAL OFFICE EXPENSES</b>	
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)	2,265
	EQUIPMENT REPAIR & MAINTENANCE	0
	OUTSIDE CLERICAL SERVICES	17,500
	PENALTIES / OVERDRAFT CHARGES VI 18	13,712
	HOME OFFICE EXPENSE	0
	THEFT & DAMAGE LOSS	0
	TELEPHONE	46,227
	MESSENGER SERVICE	0
	STAFF DEVELOPMENT	1,148
		80,852

LINE	SCHED REF	TOTAL
22	<b>EMPLOYEE BENEFITS &amp; PAYROLL TAXES</b>	
	FICA TAXES XIX D	270,060
	UNEMPLOYMENT COMPENSATION XIX D	89,117
	WORKERS COMPENSATION INSURANC XIX D	71,385
	HOSPITALIZATION INSURANCE XIX D	215,689
	EMPLOYEE BENEFITS - OTHER XIX D	2,343
	EMPLOYEE PHYSICAL EXAMS XIX D	0
	INSURANCE - EXECUTIVE LIFE VI 21/XIX D	0
	PENSION/PROFIT SHARING PLANS XIX D	0
	CHICAGO HEAD TAX XIX D	7,284
		0
		655,878
23	<b>INSERVICE TRAINING &amp; EDUCATION</b>	
	EDUCATION & SEMINARS	0
		0
24	<b>TRAVEL &amp; SEMINARS</b>	
	EDUCATION & SEMINARS XIX G	1,712
	TRAVEL XIX G	0
		1,712
25	<b>ADMIN. STAFF TRANSPORTATION</b>	
	TRANSPORTATION - STAFF	3,980
		3,980
26	<b>INSURANCE - PROP. LIAB &amp; MALPRACTICE</b>	
	GENERAL INSURANCE	99,133
		99,133
27	<b>OTHER</b>	
	BAD DEBTS VI 24	254,953
		254,953

GRAND TOTAL COLUMN 3 OTHER

1,826,116

**SOUTHVIEW MANOR  
SCHEDULES  
12/31/2008**

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

TOTAL FOOD PURCHASE	322,729
LESS SALES TAX	<u>(1,616)</u>
NET FOOD	321,113

TOTAL PATIENT CENSUS	71,506
TIME 3 MEALS PER DAY	<u>3</u>
TOTAL PATIENT MEALS	214,518

ADD # EMPLOYEE MEALS/DAY	0
TIME # DAYS	<u>366</u>
TOTAL EMPLOYEE MEALS	0

PATIENT MEALS	214,518
ADD EMPLOYEE MEALS	<u>0</u>
TOTAL MEALS/YEAR	214,518

NET FOOD	321,113
DIVIDE TOTAL MEALS/YEAR	<u>214,518</u>

COST PER MEAL	1.50
TIME EMPLOYEE MEALS	<u>0</u>
EMPLOYEE MEAL RECLASSIFICATION	<b>0</b>

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V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY	
		Salary/Wage	Supplies	Other	Total					9	10
	D. Ownership	1	2	3	4	5	6	7	8		
30	Depreciation			13,545	13,545		13,545	(7,255)	6,290		30
31	Amortization of Pre-Op. & Org.										31
32	Interest			54,881	54,881		54,881	(23,558)	31,323		32
33	Real Estate Taxes			238,215	238,215		238,215		238,215		33
34	Rent-Facility & Grounds			1,676,925	1,676,925		1,676,925		1,676,925		34
35	Rent-Equipment & Vehicles			60,700	60,700		60,700	3,270	63,970		35
36	Other (specify):*							(1,177)	(1,177)		36
37	<b>TOTAL Ownership</b>			2,044,266	2,044,266		2,044,266	(28,720)	2,015,546		37
	<b>Ancillary Expense</b>										
	<b>E. Special Cost Centers</b>										
38	Medically Necessary Transportation										38
39	Ancillary Service Centers		107,987	82,744	190,731		190,731		190,731		39
40	Barber and Beauty Shops										40
41	Coffee and Gift Shops										41
42	Provider Participation Fee			109,800	109,800		109,800		109,800		42
43	Other (specify):*										43
44	<b>TOTAL Special Cost Centers</b>		107,987	192,544	300,531		300,531		300,531		44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	3,532,536	721,439	4,062,926	8,316,901		8,316,901	(389,306)	7,927,595		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	
	<b>NON-ALLOWABLE EXPENSES</b>	<b>Amount</b>	<b>Refer- ence</b>	<b>BHF USE ONLY</b>	
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	(7,611)	30		9
10	Interest and Other Investment Income	(23,558)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,616)	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	(13,712)	21		18
19	Entertainment		20		19
20	Contributions	(8,438)	20		20
21	Owner or Key-Man Insurance		22		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(254,953)	27		24
25	Fund Raising, Advertising and Promotional	(2,604)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising		20		28
29	Other-Attach Schedule	(43,805)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (356,297)		\$	30

<b>BHF USE ONLY</b>							
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	
		<b>Amount</b>	<b>Reference</b>	
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)	(33,009)		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ (33,009)		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ (389,306)		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	
		<b>Yes</b>	<b>No</b>	<b>Amount</b>	<b>Reference</b>	
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	<b>TOTAL (C): (sum of lines 38-46)</b>			\$		47

SOUTHVIEW MANOR

ID# 0048421

Report Period Beginning: 01/01/2008

Ending: 12/31/2008

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	DEFERRED MAINTENANCE	\$	6	1
2	STAFF DEVELOPMENT	(1,148)	21	2
3	MARKETING SALARY	(39,215)	21	3
4	BANK CHARGE	(2,265)	21	4
5	AUTO LEASE	(1,177)	36	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	<b>Total</b>	(43,805)		49

## STATE OF ILLINOIS

Summary A

Facility Name & ID Number SOUTHVIEW MANOR# 0048421

Report Period Beginning:

01/01/2008

Ending:

12/31/2008

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
		(to Sch V, col.7)												
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(1,616)	0	0	0	0	0	0	0	0	0	0	(1,616)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	1,622	0	0	0	0	0	0	0	1,622	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	3,116	2,159	0	0	0	0	0	0	0	5,275	6
7	Other (specify):*	0	0	0	72	0	0	0	0	0	0	0	72	7
8	<b>TOTAL General Services</b>	<b>(1,616)</b>	<b>0</b>	<b>3,116</b>	<b>3,853</b>	<b>0</b>	<b>5,353</b>	<b>8</b>						
	<b>B. Health Care and Programs</b>													
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	<b>TOTAL Health Care and Programs</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative	0	(69,497)	(36,553)	10,280	0	0	0	0	0	0	0	(95,770)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	97	323	9,857	0	0	0	0	0	0	0	10,277	19
20	Fees, Subscriptions & Promotions	(11,042)	0	0	2,608	0	0	0	0	0	0	0	(8,434)	20
21	Clerical & General Office Expenses	(56,340)	0	8,327	13,280	0	0	0	0	0	0	0	(34,733)	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	8	0	0	0	0	0	0	0	8	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	488	674	0	0	0	0	0	0	0	1,162	25
26	Insurance-Prop.Liab.Malpractice	0	0	641	506	0	0	0	0	0	0	0	1,147	26
27	Other (specify):*	(254,953)	0	8,966	6,391	0	0	0	0	0	0	0	(239,596)	27
28	<b>TOTAL General Administration</b>	<b>(322,335)</b>	<b>(69,400)</b>	<b>(17,808)</b>	<b>43,604</b>	<b>0</b>	<b>(365,939)</b>	<b>28</b>						
29	<b>TOTAL Operating Expense</b> (sum of lines 8,16 & 28)	<b>(323,951)</b>	<b>(69,400)</b>	<b>(14,692)</b>	<b>47,457</b>	<b>0</b>	<b>(360,586)</b>	<b>29</b>						

## STATE OF ILLINOIS

Summary B

Facility Name & ID Number SOUTHVIEW MANOR# 0048421

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)	
	<b>D. Ownership</b>													
30	Depreciation	(7,611)	0	111	245	0	0	0	0	0	0	0	(7,255)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(23,558)	0	0	0	0	0	0	0	0	0	0	(23,558)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	579	2,691	0	0	0	0	0	0	0	3,270	35
36	Other (specify):*	(1,177)	0	0	0	0	0	0	0	0	0	0	(1,177)	36
37	<b>TOTAL Ownership</b>	<b>(32,346)</b>	<b>0</b>	<b>690</b>	<b>2,936</b>	<b>0</b>	<b>(28,720)</b>	<b>37</b>						
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
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	<b>TOTAL Special Cost Centers</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>44</b>
45	<b>GRAND TOTAL COST (sum of lines 29, 37 &amp; 44)</b>	<b>(356,297)</b>	<b>(69,400)</b>	<b>(14,002)</b>	<b>50,393</b>	<b>0</b>	<b>(389,306)</b>	<b>45</b>						

**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
				6865 FIN. INC	LINCOLNWOOD	MANAGEMENT
SEE ATTACHED SCHEDULE		SEE ATTACHED SCHEDULE		EMI ENTERPRISE	LINCOLNWOOD	MANAGEMENT
				EKS MGMT	LINCOLNWOOD	BOOKKEEPING
				IME REALTY	LINCOLNWOOD	HOME OFFICE

**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	17	MANAGEMNT FEES	\$ 296,712	6865 FINANCIAL INC		\$	(296,712)	1
2	V	17	SHELDON NEIDICH			90,000		90,000	2
3	V	17	EMI ENTERPRISES			60,057		60,057	3
4	V	17	PHILIP ESFORMES INC			60,057		60,057	4
5	V	17	DANIEL WEISS			4,171		4,171	5
6	V	17	AVRUM WEINFELD			12,930		12,930	6
7	V	19	ACCOUNTING FEES			97		97	7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total		\$ 296,712			\$ 227,312	\$ *	(69,400)	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 FEE	\$ 60,057	EMI ENTERPRISES, INC.		\$	\$ (60,057)
16	V	6 DRIVERS SALARIES				3,116	3,116
17	V	17 M. ESFORMES - OFFICER				16,224	16,224
18	V	17 REGIONAL DIRECTOR				7,280	7,280
19	V	19 ACCOUNTING FEES				323	323
20	V	21 OFFICE				8,327	8,327
21	V	25 TRANSPORTATION				488	488
22	V	26 INSURANCE				641	641
23	V	27 EMPLOYEE BENEFITS				8,966	8,966
24	V	30 DEPRECIATION S/L				111	111
25	V	35 AUTO LEASE				579	579
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		\$ 60,057			\$ 46,055	\$ * (14,002)

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

Facility Name & ID Number

SOUTHVIEW MANOR

# 0048421

Report Period Beginning:

01/01/2008

Ending:

12/31/2008

**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	21 OUTSIDE CLERICAL	\$ 17,500	EKS MANAGEMENT INC		\$	\$(17,500)
16	V	4 HOUSEKEEPING SALARIES				1,622	1,622
17	V	6 PAINTERS SALARIES				2,159	2,159
18	V	7 SCAVENGER				72	72
19	V	17 CFO - SALARY				10,280	10,280
20	V	19 PROFESSIONAL FEES				9,857	9,857
21	V	20 WANT ADS / BACKGR CKS				2,608	2,608
22	V	21 OFFICE				30,780	30,780
23	V	23 SEMINARS				8	8
24	V	25 TRANSPORTATION				674	674
25	V	26 INSURANCE				506	506
26	V	27 EMPLOYEE BENEFITS				6,391	6,391
27	V	30 DEPRECIATION S/L				245	245
28	V	35 EQUIPMENT RENT				2,691	2,691
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 17,500			\$ 67,893	\$ * 50,393

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

Facility Name &amp; ID Number

SOUTHVIEW MANOR

#

0048421

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	<u>SHELDON NEIDICH</u>		<u>Administrative</u>	<u>32.66</u>		<u>List</u>		<u>Comp fr 6865</u>	<u>\$ 90,000</u>	<u>17-7</u>	<u>1</u>
2						<u>Attached</u>					<u>2</u>
3	<u>MORRIS ESFORMES</u>		<u>Administrative</u>	<u>32.66</u>		<u>List</u>		<u>Comp fr EMI</u>	<u>16,224</u>	<u>17-7</u>	<u>3</u>
4						<u>Attached</u>		<u>ADM CONS</u>	<u>23,285</u>	<u>19-3</u>	<u>4</u>
5	<u>PHILIP ESFORMES</u>		<u>Administrative</u>	<u>32.67</u>		<u>List</u>		<u>Comp fr 6865</u>	<u>60,057</u>	<u>17-7</u>	<u>5</u>
6						<u>Attached</u>					<u>6</u>
7	<u>DANIEL WEISS</u>		<u>Administrative</u>					<u>Comp fr 6865</u>	<u>4,171</u>	<u>17-7</u>	<u>7</u>
8											<u>8</u>
9	<u>FLORA WEISS</u>		<u>Clerical</u>					<u>Comp fr EKS</u>	<u>1,392</u>	<u>21-7</u>	<u>9</u>
10											<u>10</u>
11	<u>AVRUM WEINFELD</u>		<u>Administrative</u>	<u>2.00</u>		<u>List</u>		<u>Comp fr 6865</u>	<u>12,930</u>	<u>17-7</u>	<u>11</u>
12						<u>Attached</u>		<u>Comp fr EKS</u>	<u>10,280</u>	<u>17-7</u>	<u>12</u>
13								<b>TOTAL</b>	<b>\$ 218,339</b>		<b>13</b>

\* 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 SOUTHVIEW MANOR

# 0048421 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 6865 FINANCIAL INC  
 Street Address 6865 N. LINCOLN AVE  
 City / State / Zip Code LINCOLNWOOD, IL. 60712  
 Phone Number ( 847 ) 674-5795  
 Fax Number ( 847 ) 674-5794

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	17	SHELDON NEIDICH	DIRECT	1	\$ 90,000	\$ 90,000	1	\$ 90,000	1
2	17	EMI ENTERPRISES	PATIENT DAYS	514,353	10	432,000	71,506	60,057	2
3	17	PHILIP ESFORMES INC	PATIENT DAYS	514,353	10	432,000	71,506	60,057	3
4	17	DANIEL WEISS	PATIENT DAYS	514,353	10	30,000	71,506	4,171	4
5	17	AVRUM WEINFELD	PATIENT DAYS	514,353	10	93,005	71,506	12,930	5
6	19	ACCOUNTING FEES	PATIENT DAYS	514,353	10	700	71,506	97	6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 1,077,705	\$ 645,005		\$ 227,312	25

Facility Name & ID Number **SOUTHVIEW MANOR**

# **0048421**

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 EMI ENTERPRISES INC  
 Street Address 6865 N. LINCOLN AVE  
 City / State / Zip Code LINCOLNWOOD,IL. ,60712  
 Phone Number ( 847)674-5795  
 Fax Number ( 847)674-5794

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6		
1	6	DRIVERS SALARIES	PATIENT DAYS	859,462	14	\$ 37,451	\$ 37,451	71,506	\$ 3,116	1
2	17	M. ESFORMES - OFFICER	PATIENT DAYS	859,462	14	195,000	195,000	71,506	16,224	2
3	17	REGIONAL DIRECTOR	PATIENT DAYS	859,462	14	87,500	87,500	71,506	7,280	3
4	19	ACCOUNTING FEES	PATIENT DAYS	859,462	14	3,885		71,506	323	4
5	21	OFFICE	PATIENT DAYS	859,462	14	100,089	57,703	71,506	8,327	5
6	25	TRANSPORTATION	PATIENT DAYS	859,462	14	5,861		71,506	488	6
7	26	INSURANCE	PATIENT DAYS	859,462	14	7,710		71,506	641	7
8	27	EMPLOYEE BENEFITS	PATIENT DAYS	859,462	14	107,763		71,506	8,966	8
9	30	DEPRECIATION S/L	PATIENT DAYS	859,462	14	1,340		71,506	111	9
10	35	AUTO LEASE	PATIENT DAYS	859,462	14	6,960		71,506	579	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					\$ 553,559	\$ 377,654		\$ 46,055	25

Facility Name & ID Number **SOUTHVIEW MANOR**

# **0048421**

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 EKS MANAGEMENT, INC.  
 Street Address 6865 N. LINCOLN AVE  
 City / State / Zip Code LINCOLNWOOD,IL. ,60712  
 Phone Number ( 847 )674-5795  
 Fax Number ( 847 )674-5794

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	4	HOUSEKEEPING SALARIES	PATIENT DAYS	859,462	14	\$ 19,500	\$ 71,506	\$ 1,622	1
2	6	PAINTERS SALARIES	PATIENT DAYS	859,462	14	25,953	71,506	2,159	2
3	7	SCAVENGER	PATIENT DAYS	859,462	14	866	71,506	72	3
4	17	CFO - SALARY	PATIENT DAYS	859,462	14	123,563	71,506	10,280	4
5	19	PROFESSIONAL FEES	PATIENT DAYS	859,462	14	118,475	71,506	9,857	5
6	20	WANT ADS / BACKGR CKS	PATIENT DAYS	859,462	14	31,349	71,506	2,608	6
7	21	OFFICE	PATIENT DAYS	859,462	14	369,953	71,506	30,780	7
8	23	SEMINARS	PATIENT DAYS	859,462	14	95	71,506	8	8
9	25	TRANSPORTATION	PATIENT DAYS	859,462	14	8,106	71,506	674	9
10	26	INSURANCE	PATIENT DAYS	859,462	14	6,085	71,506	506	10
11	27	EMPLOYEE BENEFITS	PATIENT DAYS	859,462	14	76,819	71,506	6,391	11
12	30	DEPRECIATION S/L	PATIENT DAYS	859,462	14	2,943	71,506	245	12
13	35	EQUIPMENT RENT	PATIENT DAYS	859,462	14	32,345	71,506	2,691	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					\$ 816,052	\$ 521,578	\$ 67,893	25

Facility Name & ID Number

SOUTHVIEW MANOR

# 0048421

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	2	3	4	5	6	7	8	9	10											
										Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
											YES	NO				Original	Balance			
<b>A. Directly Facility Related</b>																				
<b>Long-Term</b>																				
1																				
2																				
3																				
4																				
5																				
<b>Working Capital</b>																				
6	ALBANY BANK	X	WORKING CAPITAL	INTEREST	REVOLV		1,970,000	REVOLV	PRIME +	54,881										
7																				
8																				
9	<b>TOTAL Facility Related</b>					\$	1,970,000			\$ 54,881										
<b>B. Non-Facility Related*</b>																				
10	IRS, IDR, ETC	X	LATE FEES																	
11																				
12																				
13																				
14	<b>TOTAL Non-Facility Related</b>					\$				\$										
15	<b>TOTALS (line 9+line14)</b>					\$	1,970,000			\$ 54,881										

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

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

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

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

**B. Real Estate Taxes**

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

1. Real Estate Tax accrual used on 2007 report.		\$	<b>243,413</b>	<b>1</b>
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.)		\$	<b>240,814</b>	<b>2</b>
3. Under or (over) accrual (line 2 minus line 1).		\$	<b>(2,599)</b>	<b>3</b>
4. Real Estate Tax accrual used for 2008 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	<b>240,814</b>	<b>4</b>
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>		\$		<b>5</b>
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. <b>TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>		\$		<b>6</b>
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	<b>238,215</b>	<b>7</b>

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	<b>2003</b>	<b>237,359</b>	<b>8</b>
	<b>2004</b>	<b>208,985</b>	<b>9</b>
	<b>2005</b>	<b>211,113</b>	<b>10</b>
	<b>2006</b>	<b>243,413</b>	<b>11</b>
	<b>2007</b>	<b>240,814</b>	<b>12</b>

<b>FOR BHF USE ONLY</b>			
<b>13</b>	FROM R. E. TAX STATEMENT FOR 2007	\$	<b>13</b>
<b>14</b>	PLUS APPEAL COST FROM LINE 5	\$	<b>14</b>
<b>15</b>	LESS REFUND FROM LINE 6	\$	<b>15</b>
<b>16</b>	AMOUNT TO USE FOR RATE CALCULATION	\$	<b>16</b>

**NOTES:**

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

**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 SOUTHVIEW MANOR COUNTY COOK

FACILITY IDPH LICENSE NUMBER 0048421

CONTACT PERSON REGARDING THIS REPORT BOB KAGDA

TELEPHONE ( 847 ) 675-3585 FAX #: ( 847 ) 675-5777

**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>17-34-116-003-000</u>	<u>NURSING HOME</u>	\$ <u>83,474.66</u>	\$ <u>83,474.66</u>
2. <u>17-34-116-004-000</u>	<u>NURSING HOME</u>	\$ <u>47,477.76</u>	\$ <u>47,477.76</u>
3. <u>17-34-116-005-000</u>	<u>NURSING HOME</u>	\$ <u>35,996.80</u>	\$ <u>35,996.80</u>
4. <u>17-34-116-006-000</u>	<u>NURSING HOME</u>	\$ <u>35,996.90</u>	\$ <u>35,996.90</u>
5. <u>17-34-116-007-000</u>	<u>NURSING HOME</u>	\$ <u>35,996.80</u>	\$ <u>35,996.80</u>
6. <u>17-34-116-008-000</u>	<u>NURSING HOME</u>	\$ <u>1,871.15</u>	\$ <u>1,871.15</u>
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ <u>240,814.07</u>	\$ <u>240,814.07</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.



**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				\$	\$		\$	\$	\$	4
5										5
6										6
7	RELATED HOME									7
8	OFFICE			46,019						8
<b>Improvement Type**</b>										
9	ELEVATOR REPAIR		2007	19,816	721	27.5	721		1,232	9
10	TELEPHONE SYSTEM		2007	13,100	476	27.5	476		932	10
11	WATER HEATER		2007	32,500	1,182	27.5	1,182		2,019	11
12	ROOF REPAIR		2008	14,800	247	27.5	247		247	12
13	60 TON CHILLER		2008	71,075	1,184	27.5	1,184		1,184	13
14	PUMP GASKETS, OIL TANK COOLERS		2008	9,115	69	27.5	69		69	14
15	OIL COOLERS, PUMP SEALS		2008	19,285	146	27.5	146		146	15
16	AWNING		2008	3,000	23	27.5	23		23	16
17	FENCE		2008	3,960	132	15	132		132	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

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

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

See Page 12A, Line 70 for total

**XI. OWNERSHIP COSTS (continued)**

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67								67
68								68
69								69
70	TOTAL (lines 4 thru 69)	\$ 232,670	\$ 4,180		\$ 4,180	\$	\$ 5,984	70

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

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 13,276	\$ 4,248	\$ 1,328	\$ (2,920)	10 YRS	\$ 1,328	71
72	Current Year Purchases	8,528	5,117	426	(4,691)	10 YRS	426	72
73	Fully Depreciated Assets							73
74	RELATED PARTY		356	356				74
75	TOTALS	\$ 21,804	\$ 9,721	\$ 2,110	\$ (7,611)		\$ 1,754	75

D. Vehicle Depreciation (See instructions.)\*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 254,474	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 13,901	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 6,290	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (7,611)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 7,738	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: GRANITE SOUTH VIEW, LLC

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

If NO, see instructions.  YES  NO

	1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:	<u>200</u>	<u>11/01/06</u>	\$ <u>1,676,925</u>	<u>5.5</u>	<u>5</u>	3
4	Additions						4
5							5
6							6
7	TOTAL	<u>200</u>		\$ <u>1,676,925</u>			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: \$ 43,591 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			\$ _____	\$ <u>17,109</u>	17
18					18
19					19
20					20
21	TOTAL		\$ _____	\$ <u>17,109</u>	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 \$ 1,697,834

13. /2010 \$ 1,697,834

14. /2011 \$ \_\_\_\_\_

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

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

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

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

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

**B. EXPENSES**

**ALLOCATION OF COSTS (d)**

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

**C. CONTRACTUAL INCOME**

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

\$

**D. NUMBER OF CNAs TRAINED**

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

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

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

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39-3	hrs	\$		\$ 47,312	\$		\$ 47,312	1
2	Licensed Speech and Language Development Therapist	39-3	hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			35,432			35,432	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				104,395		104,395	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): <u>lab</u>	39-2					3,592		3,592	13
14	<b>TOTAL</b>			\$		\$ 82,744	\$ 107,987		\$ 190,731	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 SOUTHVIEW MANOR

# 0048421

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*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 163,464	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (240,000) )	3,318,933		3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	123,881		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): R.E. & INS Escrow	177,227		9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 3,783,505	\$	10
	<b>B. Long-Term Assets</b>			
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	186,651		15
16	Equipment, at Historical Cost	21,804		16
17	Accumulated Depreciation (book methods)	(18,004)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	494,686		21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 685,137	\$	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 4,468,642	\$	25

		1	2	
		Operating	After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 1,123,128	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	1,970,000		29
30	Accrued Salaries Payable	194,104		30
31	Accrued Taxes Payable (excluding real estate taxes)	33,409		31
32	Accrued Real Estate Taxes(Sch.IX-B)	240,814		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36				36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 3,561,455	\$	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43				43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$	\$	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 3,561,455	\$	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 907,187	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 4,468,642	\$	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1 Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>953,820</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>	<b>ROUNDING</b>	<b>(2)</b>	<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>953,818</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>(46,631)</b>	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	( )	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ <b>(46,631)</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>907,187</b>	<b>24</b> *

\* 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	
	<b>A. Inpatient Care</b>		
1	Gross Revenue -- All Levels of Care	\$ 8,229,339	1
2	Discounts and Allowances for all Levels	( )	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 8,229,339	3
	<b>B. Ancillary Revenue</b>		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	17,373	6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 17,373	8
	<b>C. Other Operating Revenue</b>		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		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	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$	23
	<b>D. Non-Operating Revenue</b>		
24	Contributions		24
25	Interest and Other Investment Income***	23,558	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 23,558	26
	<b>E. Other Revenue (specify):****</b>		
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28			28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 8,270,270	30

2

	Expenses	Amount	
	<b>A. Operating Expenses</b>		
31	General Services	1,752,120	31
32	Health Care	2,366,012	32
33	General Administration	1,853,972	33
	<b>B. Capital Expense</b>		
34	Ownership	2,044,266	34
	<b>C. Ancillary Expense</b>		
35	Special Cost Centers	190,731	35
36	Provider Participation Fee	109,800	36
	<b>D. Other Expenses (specify):</b>		
37	<b>OUT-OF-PERIOD EXPENSES</b>		37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 8,316,901	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	(46,631)	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ (46,631)	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 **SOUTHVIEW MANOR**

# 0048421

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	4,336	4,505	\$ 146,627	\$ 32.55	1
2	Assistant Director of Nursing					2
3	Registered Nurses	3,937	4,336	122,199	28.18	3
4	Licensed Practical Nurses	23,429	25,896	939,962	36.30	4
5	CNAs & Orderlies	64,638	70,469	629,310	8.93	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,974	2,104	21,936	10.43	8
9	Activity Director					9
10	Activity Assistants	9,283	10,085	101,482	10.06	10
11	Social Service Workers	11,433	11,959	177,418	14.84	11
12	Dietician	21,906	23,838	230,768	9.68	12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers	11,465	11,872	186,185	15.68	17
18	Housekeepers	31,206	33,778	316,801	9.38	18
19	Laundry	6,107	6,767	58,266	8.61	19
20	Administrator	2,499	2,650	92,975	35.08	20
21	Assistant Administrator	3,103	3,254	67,420	20.72	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	17,547	18,160	166,770	9.18	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	2,095	2,135	30,905	14.48	31
32	Other Health C: <u>MDS, QA</u>	4,109	4,132	73,439	17.77	32
33	Other(specify) <u>SECURITY</u>	19,032	19,959	170,073	8.52	33
34	TOTAL (lines 1 - 33)	238,099	255,899	\$ 3,532,536 *	\$ 13.80	34

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

\*\* See instructions.

**B. CONSULTANT SERVICES**

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference		
35	Dietary Consultant	M	\$ 12,621	1-3	35
36	Medical Director	O	6,700	9-3	36
37	Medical Records Consultant	N	1,870	10-3	37
38	Nurse Consultant	T	0	10-3	38
39	Pharmacist Consultant	H	5,940	10-3	39
40	Physical Therapy Consultant	L	0	10a-3	40
41	Occupational Therapy Consultant	Y	606	10a-3	41
42	Respiratory Therapy Consultant		0	10a-3	42
43	Speech Therapy Consultant	F	0	10a-3	43
44	Activity Consultant	E	1,958	11-3	44
45	Social Service Consultant	E	3,164	12-3	45
46	Other(specify) <u>Dental</u>	S	4,800	10-3	46
47	<u>Psychiatric Consultant</u>		4,800	10-3	47
48					48
49	TOTAL (lines 35 - 48)		\$ 42,459		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			10-3	51
52	Certified Nurse Assistants/Aides			10-3	52
53	TOTAL (lines 50 - 52)		\$		53





Facility Name &amp; ID Number SOUTHVIEW MANOR

# 0048421

Report Period Beginning: 01/01/2008

Ending: 12/31/2008

**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? YES
- (2) Are there any dues to nursing home associations included on the cost report? YES  
If YES, give association name and amount. IL COUNCIL LONG TERM CARE \$7,838
- (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. \$ 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? \_\_\_\_\_  
If YES, give effective date of lease. \_\_\_\_\_
- (9) Are you presently operating under a sublease agreement? \_\_\_\_\_ YES \_\_\_\_\_ NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES X NO \_\_\_\_\_ If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.  
SOUTHVIEW MANOR INC #0038943 11/01/06
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 109,800  
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. \$ 0 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