

Facility Name & ID Number Lake Shore Healthcare & Rehabilitation

0035048 Report Period Beginning: 1-Jan-2009 Ending: 31-Dec-2009

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	313	Skilled (SNF)	313	114,245	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	313	TOTALS	313	114,245	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment				5 Total	
		3 Medicaid Recipient	4 Private Pay	Other	Total		
8	SNF	3,259	586	11,437	15,282	8	
9	SNF/PED					9	
10	ICF					10	
11	ICF/DD	53,682	3,093	785	57,560	11	
12	SC					12	
13	DD 16 OR LESS					13	
14	TOTALS	56,941	3,679	12,222	72,842	14	

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 63.76%

D. How many bed-hold days during this year were paid by the Department?

None (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 1st March 1989

J. Was the facility purchased or leased after January 1, 1978?

YES Date 28th July 1992 NO

K. Was the facility certified for Medicare during the reporting year?

YES NO If YES, enter number of beds certified 313 and days of care provided 9,574

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: 31st Dec 2009 Fiscal Year: 31st Dec 2009

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

Facility Name & ID Number Lake Shore Healthcare & Rehabilitation # 0035048 Report Period Beginning: 1-Jan-2009 Ending: 31-Dec-2009

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	580,231	125,889	58,492	764,612		764,612		764,612		1
2	Food Purchase		579,030		579,030	(46,746)	532,284	(259)	532,025		2
3	Housekeeping	383,347	140,634		523,981		523,981		523,981		3
4	Laundry	226,552	59,940		286,492		286,492		286,492		4
5	Heat and Other Utilities			439,694	439,694		439,694		439,694		5
6	Maintenance	123,980	68,628	278,254	470,862		470,862	2,315	473,177		6
7	Other (specify):*										7
8	TOTAL General Services	1,314,110	974,121	776,440	3,064,671	(46,746)	3,017,925	2,056	3,019,981		8
	B. Health Care and Programs										
9	Medical Director			60,000	60,000		60,000		60,000		9
10	Nursing and Medical Records	5,267,695	515,241	503,271	6,286,207		6,286,207		6,286,207		10
10a	Therapy			18,767	18,767		18,767		18,767		10a
11	Activities	181,258	35,146		216,404		216,404		216,404		11
12	Social Services	127,532	4,116		131,648		131,648		131,648		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* *Dental Service**			6,972	6,972		6,972		6,972		15
16	TOTAL Health Care and Programs	5,576,485	554,503	589,010	6,719,998		6,719,998		6,719,998		16
	C. General Administration										
17	Administrative	147,208		490,560	637,768		637,768	(248,915)	388,853		17
18	Directors Fees										18
19	Professional Services			76,611	76,611		76,611	8,712	85,323		19
20	Dues, Fees, Subscriptions & Promotions			27,137	27,137		27,137	(5,621)	21,516		20
21	Clerical & General Office Expenses	249,971	57,608	122,607	430,186		430,186	111,230	541,416		21
22	Employee Benefits & Payroll Taxes			1,119,775	1,119,775	46,746	1,166,521	16,717	1,183,238		22
23	Inservice Training & Education			3,164	3,164		3,164	5,481	8,645		23
24	Travel and Seminar			2,885	2,885		2,885	2,366	5,251		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			16,640	16,640		16,640		16,640		26
27	Other (specify):* *Payroll Taxes (Sch VII)							37,593	37,593		27
28	TOTAL General Administration	397,179	57,608	1,859,379	2,314,166	46,746	2,360,912	(72,437)	2,288,475		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	7,287,774	1,586,232	3,224,829	12,098,835		12,098,835	(70,381)	12,028,454		29

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

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

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	D. Ownership										
30	Depreciation			42,512	42,512		42,512	349,612	392,124		30
31	Amortization of Pre-Op. & Org.										31
32	Interest			27,771	27,771		27,771	214,222	241,993		32
33	Real Estate Taxes			351,491	351,491		351,491		351,491		33
34	Rent-Facility & Grounds			846,618	846,618		846,618	(840,000)	6,618		34
35	Rent-Equipment & Vehicles			3,659	3,659		3,659		3,659		35
36	Other (specify):* Gain on Sale of Assets							(28,223)	(28,223)		36
37	TOTAL Ownership			1,272,051	1,272,051		1,272,051	(304,389)	967,662		37
	Ancillary Expense										
	E. Special Cost Centers										
38	Medically Necessary Transportation										38
39	Ancillary Service Centers		685,156	893,535	1,578,691		1,578,691		1,578,691		39
40	Barber and Beauty Shops										40
41	Coffee and Gift Shops										41
42	Provider Participation Fee			171,368	171,368		171,368		171,368		42
43	Other (specify):*										43
44	TOTAL Special Cost Centers		685,156	1,064,903	1,750,059		1,750,059		1,750,059		44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	7,287,774	2,271,388	5,561,783	15,120,945		15,120,945	(374,770)	14,746,175		45

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

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(29,827)	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	(259)	2		13
14	Non-Care Related Interest	(3,139)	32		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		24		19
20	Contributions	(74)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(52,277)	21		24
25	Fund Raising, Advertising and Promotional	(105,781)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax		21		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising		20		28
29	Other-Attach Schedule	(1,918)	6		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (193,275)		\$	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)	(181,495)	Pg 6& 6A	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (181,495)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (374,770)		37

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

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

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

BHF USE ONLY							
48		49		50		51	52

Lake Shore Healthcare & Rehabilitation

ID# 0035048

Report Period Beginning: 1-Jan-2009

Ending: 31-Dec-2009

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Deferred Maintenance Expenses (incurred in 2009)	\$ (10,032)	6	1
2	Deferred Maintenance Exps (allocated for 2009)	8,114	6	2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(1,918)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Lake Shore Healthcare & Rehabilitation# 0035048

Report Period Beginning:

1-Jan-2009

Ending:

31-Dec-2009

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	(259)	0	0	0	0	0	0	0	0	0	0	(259)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	(1,918)	4,233	0	0	0	0	0	0	0	0	0	2,315	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(2,177)	4,233	0	0	0	0	0	0	0	0	0	2,056	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	(498,915)	250,000	0	0	0	0	0	0	0	0	(248,915)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	7,012	1,700	0	0	0	0	0	0	0	0	8,712	19
20	Fees, Subscriptions & Promotions	(105,855)	100,234	0	0	0	0	0	0	0	0	0	(5,621)	20
21	Clerical & General Office Expenses	(52,277)	163,292	215	0	0	0	0	0	0	0	0	111,230	21
22	Employee Benefits & Payroll Taxes	0	16,717	0	0	0	0	0	0	0	0	0	16,717	22
23	Inservice Training & Education	0	5,481	0	0	0	0	0	0	0	0	0	5,481	23
24	Travel and Seminar	0	2,366	0	0	0	0	0	0	0	0	0	2,366	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	37,593	0	0	0	0	0	0	0	0	0	37,593	27
28	TOTAL General Administration	(158,132)	(166,220)	251,915	0	(72,437)	28							
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(160,309)	(161,987)	251,915	0	(70,381)	29							

STATE OF ILLINOIS

Facility Name & ID Number Lake Shore Healthcare & Rehabilitation# 0035048

Report Period Beginning:

1-Jan-2009 Ending:

Summary B

31-Dec-2009

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	(29,827)	5,642	373,797	0	0	0	0	0	0	0	0	349,612	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(3,139)	(5,826)	223,187	0	0	0	0	0	0	0	0	214,222	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	(840,000)	0	0	0	0	0	0	0	0	(840,000)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	(28,223)	0	0	0	0	0	0	0	0	(28,223)	36
37	TOTAL Ownership	(32,966)	(184)	(271,239)	0	(304,389)	37							
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(193,275)	(162,171)	(19,324)	0	0	0	0	0	0	0	0	(374,770)	45

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business

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	17 Management Fee Income	\$ 740,560	Lancaster, Ltd.	100.00%	\$	(740,560)	1
2	V	17 Officers' Salaries		Lancaster, Ltd.	100.00%	93,270	93,270	2
3	V	27 Payroll Taxes-Officers & Staff		Lancaster, Ltd.	100.00%	37,593	37,593	3
4	V	19 Professional Services		Lancaster, Ltd.	100.00%	7,012	7,012	4
5	V	21 Clerical Expenses		Lancaster, Ltd.	100.00%	163,292	163,292	5
6	V	22 Employee Benefits		Lancaster, Ltd.	100.00%	16,717	16,717	6
7	V	24 Seminars & Travel		Lancaster, Ltd.	100.00%	2,366	2,366	7
8	V	17 Administrative Consulting		Lancaster, Ltd.	100.00%	148,375	148,375	8
9	V	20 Dues,Subscriptions & Marketing Fees		Lancaster, Ltd.	100.00%	100,234	100,234	9
10	V	30 Depreciation		Lancaster, Ltd.	100.00%	5,642	5,642	10
11	V	32 Interest-Incl. Direct Interest	18,739	Lancaster, Ltd.	100.00%	12,913	(5,826)	11
12	V	23 Education & Inservice		Lancaster, Ltd.	100.00%	5,481	5,481	12
13	V	6 Repairs & Maintenance		Lancaster, Ltd.	100.00%	4,233	4,233	13
14	Total		\$ 759,299			\$ 597,128	\$ * (162,171)	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	34 Rental Income	\$ 840,000	Lake Shore Associates		\$	\$ (840,000)
16	V	30 Depreciation		Lake Shore Associates		373,797	373,797
17	V	32 Interest	9,032	Lake Shore Associates		232,219	223,187
18	V	17 Management Fee		Lake Shore Associates		250,000	250,000
19	V	19 Accounting Fees		Lake Shore Associates		1,700	1,700
20	V	21 Illinois State Replacement tax		Lake Shore Associates		215	215
21	V	36 Gain on Sale of Assets	28,223	Lake Shore Associates			(28,223)
22	V						
23	V						
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 877,255			\$ 857,931	\$ * (19,324)

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

Facility Name & ID Number Lake Shore Healthcare & Rehabilitation # 0035048 Report Period Beginning: 1-Jan-2009 Ending: 31-Dec-2009

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	Christopher Vicere	VP-Finance	Administrative		see attached	13	27.08	Lancaster	\$ 46,635	17-7	1
2	Cheryl Morris	VP-Operations	Administrative		see attached	13	27.08	Lancaster	46,635	17-7	2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 93,270		13

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

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

Facility Name & ID Number Lake Shore Healthcare & Rehabilitation

0035048

Report Period Beginning:

1-Jan-2009

Ending: -Dec-2009

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 Lancaster, Ltd.
 Street Address 5061 N. Pulaski Road
 City / State / Zip Code Chicago, IL 60630
 Phone Number (773)604-4416
 Fax Number (773)478.1192

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	Christopher Vicere	Hours Worked	48	7	\$ 172,189	\$ 172,189	13	\$ 46,635	1
2	27	Christopher Vicere-payroll tax	Hours Worked	48	7	9,309		13	2,521	2
3	17	Cheryl Morris	Hours Worked	48	7	172,189	172,189	13	46,635	3
4	27	Cheryl Morris-payroll tax	Hours Worked	48	7	9,309		13	2,521	4
5										5
6										6
7										7
8	19	Professional Services	Management Fees	2,190,720	7	31,315		490,560	7,012	8
9	21	Clerical Expenses	Management Fees	2,190,720	7	729,221	681,138	490,560	163,292	9
10	22	Employee Benefits	Management Fees	2,190,720	7	74,654		490,560	16,717	10
11	24	Seminars and Travel	Management Fees	2,190,720	7	10,564		490,560	2,366	11
12	17	Administrative Consulting	Management Fees	2,190,720	7	662,608	662,608	490,560	148,375	12
13	20	Marketing Fees	Management Fees	2,190,720	7	430,592	417,882	490,560	96,421	13
14	20	Dues, Fees and Subscriptions	Management Fees	2,190,720	7	17,027		490,560	3,813	14
15	30	Depreciation	Management Fees	2,190,720	7	25,194		490,560	5,642	15
16	32	Interest	Management Fees	2,190,720	7	57,668		490,560	12,913	16
17	23	Education & Inservice	Management Fees	2,190,720	7	24,476		490,560	5,481	17
18	6	Repairs and Maintenance	Management Fees	2,190,720	7	18,904		490,560	4,233	18
19	27	Payroll Taxes	Management Fees	2,190,720	7	145,366		490,560	32,551	19
20										20
21	32	*Direct Interest*							(18,739)	21
22	17	Management Fee for Sale							(250,000)	22
23										23
24										24
25	TOTALS					\$ 2,590,585	\$ 2,106,006		\$ 328,389	25

Facility Name & ID Number

Lake Shore Healthcare & Rehabilitation

0035048

Report Period Beginning:

1-Jan-2009

Ending:

31-Dec-2009

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	2	3	4	5	6	7	8	9	10										
										Related**		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	JP Morgan Chase Bank		X	Commercial Loan	\$30,000.00	5/1/02	\$ 7,200,000	\$ 4,890,000		4.5500%	\$ 232,219	1							
2												2							
3												3							
4												4							
5												5							
Working Capital																			
6	JP Morgan Chase Bank		X	Working Capital							12,913	6							
7												7							
8												8							
9	TOTAL Facility Related				\$30,000.00		\$ 7,200,000	\$ 4,890,000			\$ 245,132	9							
B. Non-Facility Related*																			
10												10							
11												11							
12												12							
13												13							
14	TOTAL Non-Facility Related						\$	\$			\$	14							
15	TOTALS (line 9+line14)						\$ 7,200,000	\$ 4,890,000			\$ 245,132	15							

Less : Interest Income (3,139)

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

\$ None

Line #

N/A

241,993

Per Page 4 line 32 Col 8

* 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.)

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 92,769 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: _____ 2. Number of Years Over Which it is Being Amortized: _____
 3. Current Period Amortization: _____ 4. Dates Incurred: _____

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

XI. OWNERSHIP COSTS:

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1	Long Term Care Facility		1992	\$ 740,000	1
2	Sale of Assets as at 12-31-09			(740,000)	2
3	TOTALS			\$	3

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

1	2	3	4	5	6	7	8	9		
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	313	1992		\$ 11,667,460	\$ 354,962	40	\$ 267,379	\$ (87,583)	\$ 5,080,215	4
5										5
6				(11,667,460)					(5,080,215)	6
7										7
8										8
Improvement Type**										
9	Various		1989	24,908		10			24,908	9
10	Various		1990	80,814		10			80,814	10
11	Various		1991	28,469	3,146	20	1,021	(2,125)	27,030	11
12	Various		1992	12,856	391	20	589	198	11,161	12
13	Various		1993	68,862	1,714	20	3,157	1,443	56,534	13
14	Various		1994	5,698	139	20	263	124	4,500	14
15	Various		1995	76,433	1,694	20	3,503	1,809	55,901	15
16	Fire Alarm System		1996	54,450	1,338	20	2,496	1,158	37,895	16
17	Seamco Stone Deck		1996	7,989	196	20	366	170	5,287	17
18	Roof Exhauster		1996	2,700	66	20	124	58	1,766	18
19	Front Sign		1996	12,020	621	20	551	(70)	7,913	19
20	Water Heating System		1997	38,800	953	20	1,778	825	24,735	20
21	Fluorescent Conversion		1997	25,353	623	20	1,162	539	16,061	21
22	Elevator Improvement		1998	55,364	1,360	20	1,360		16,448	22
23	Electronic Alzheimer Doors		1998	11,800	290	20	290		3,408	23
24	Elevator Interiors		1999	34,422	846	20	846		9,124	24
25	Parking Lot Resurface		1999	20,240	1,046	20	1,046		14,264	25
26	Patio Stone Decking		1999	6,465	334	20	334		4,653	26
27	Electric Panel Board		2002	5,000	123	10	458	335	3,625	27
28	Parking Lot Fence		2003	19,707	291	10	1,204	913	8,595	28
29	Hand Rail System		2005	5,968	147	10	547	400	2,786	29
30	Wood Flooring		2005	4,248	104	10	389	285	1,983	30
31	Concrete Patio Porch		2005	8,603	211	10	789	578	3,943	31
32	Piping For Hot Water System		2005	11,900	292	10	1,091	799	5,355	32
33	Eclipse Gas Booster		2005	9,000	221	10	825	604	4,050	33
34	Wallguards		2005	2,519	62	10	231	169	1,113	34
35	Electrical Sub Panel		2005	3,370	83	10	309	226	1,460	35
36										36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Lake Shore Healthcare & Rehabilitation

0035048

Report Period Beginning:

1-Jan-2009 Ending: 31-Dec-2009

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	Concrete Work at Drain	2005	\$ 1,595	\$ 39	10	\$ 146	\$ 107	\$ 679	37
38	Heaters in Outdoor Patio	2005	2,850	70	10	261	191	1,164	38
39	Junction Box - Fire Panel	2005	780	19	10	72	53	319	39
40	Electricals for 12 Bedrooms	2005	1,600	39	10	147	108	654	40
41	Electricals for 6 Bedrooms	2005	800	20	10	73	53	320	41
42	Switches & Lights for 34 Rooms	2006	2,805	69	10	257	188	1,100	42
43	Install 28 Wall Sconces	2006	3,150	77	10	289	212	1,208	43
44	Line & Outlets - Garden Room	2006	3,580	88	10	328	240	1,342	44
45	Drilling Elevator Hole	2006	29,392	722	10	2,694	1,972	11,021	45
46	Overhaul & Install Elevator	2006	47,986	1,179	10	4,399	3,220	17,996	46
47	3 New Doors	2006	450	11	10	41	30	161	47
48	Custom Size Fire Door	2006	1,511	37	10	139	102	542	48
49	2 Stainless Steel Doors for Walk-in Freezer	2006	4,620	114	10	424	310	1,618	49
50	Renovation of 1st Floor & building new Town Square	2006	368,254	7,599	10	7,599		34,758	50
51	Lawn Pond	2007	4,853	162	20	162		648	51
52	Iron Works Fence	2007	4,194	179	20	256	77	699	52
53	Electricals for Nursing Stations	2009	15,400		5	2,567	2,567	2,567	53
54	Electricals for Hallway Closet	2009	8,375	125	10	489	364	489	54
55	Renovation of Nurses Stations	2009	3,000	39	10	150	111	150	55
56	Cabinetary at Nurses Stations	2009	4,000		5	467	467	467	56
57									57
58	Sale of Assets as at 12-31-09	2009	(1,147,153)					(513,214)	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)		\$	\$ 381,841		\$ 313,068	\$ (68,773)	\$	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	\$ 751,690	\$ 33,682	\$ 58,284	\$ 24,602		\$ 170,442	71
72	Current Year Purchases	90,102		13,478	13,478		13,478	72
73	Fully Depreciated Assets	2,085,672	786	1,652	866		2,085,672	73
74	**Assets Sold at 12/31/09 & Lancaster Depreciation**	(2,927,464)	5,642	5,642			(2,269,592)	74
75	TOTALS	\$	\$ 40,110	\$ 79,056	\$ 38,946		\$	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)	\$	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 421,951	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 392,124	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (29,827)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$	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: ** Lease held by Lakeshore Property Associates - a Related Party**

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

If NO, see instructions. YES NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5			<u>** Off-site Public Storage Space **</u>		<u>6,618</u>			5
6								6
7	TOTAL				\$ <u>6,618</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 None.

9. Option to Buy: YES NO Terms: N/A *

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: \$ 3,659 Description: Rental for Photocopying Machine @\$304.90 per month

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

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

Fiscal Year Ending Annual Rent

12. _____ /2010 \$ _____

13. _____ /2011 \$ _____

14. _____ /2012 \$ _____

* 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>
--	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39-3	hrs	\$		\$ 378,774	\$		\$ 378,774	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			110,165			110,165	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			403,366			403,366	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation **Inhalation Therapy**	39-3	hrs			1,230			1,230	8
9	Pharmacy	39-2	# of prescripts				455,558		455,558	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): **Medical Supplies**	39-2					58,560		58,560	12
13	Other (specify): **Speciality Beds**	39-2					171,038		171,038	13
14	TOTAL			\$		\$ 893,535	\$ 685,156		\$ 1,578,691	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.

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of **31-Dec-2009**

(last day of reporting year)

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

		1 Operating	2 After Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$ 41,744	\$ 41,744	1
2	Cash-Patient Deposits	20,469	20,469	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	4,315,164	4,315,164	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	63,180	63,180	7
8	Accounts Receivable (owners or related parties)		4,135,102	8
9	Other(specify): **Instalment Sale Proceeds Receivable**		12,087,500	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 4,440,557	\$ 20,663,159	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost			16
17	Accumulated Depreciation (book methods)			17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs		217,904	19
20	Accumulated Amortization - Organization & Pre-Operating Costs		(217,904)	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)	\$	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 4,440,557	\$ 20,663,159	25

		1 Operating	2 After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 436,234	\$ 436,234	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	20,469	20,469	28
29	Short-Term Notes Payable	1,304,222	4,890,000	29
30	Accrued Salaries Payable	520,973	520,973	30
31	Accrued Taxes Payable (excluding real estate taxes)	14,024	14,024	31
32	Accrued Real Estate Taxes(Sch.IX-B)	360,000	360,000	32
33	Accrued Interest Payable			33
34	Deferred Compensation		10,319,599	34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 2,655,922	\$ 16,561,299	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
Other Long-Term Liabilities(specify):				
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 2,655,922	\$ 16,561,299	46
47	TOTAL EQUITY(page 18, line 24)	\$ 1,784,635	\$ 4,101,860	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 4,440,557	\$ 20,663,159	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (581,222)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (581,222)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	2,550,857	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) ** Treasury Stock **	(185,000)	15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 2,365,857	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)	\$ 1,784,635	24 *

* This must agree with page 17, line 47.

XVI. STATEMENT OF CHANGES IN EQUITY

		Total after consolidation	
1	Balance at Beginning of Year, as Previously Reported	\$ 2,081,679	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 2,081,679	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	2,570,181	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) ** Treasury Stock **	(550,000)	15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 2,020,181	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)	\$ 4,101,860	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Lake Shore Healthcare & Rehabilitation

0035048

Report Period Beginning: 1-Jan-2009

Ending: 31-Dec-2009

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,555	1,948	\$ 76,942	\$ 39.50	1
2	Assistant Director of Nursing	5,363	5,796	192,080	33.14	2
3	Registered Nurses	62,512	66,571	1,926,054	28.93	3
4	Licensed Practical Nurses	31,614	33,832	794,974	23.50	4
5	CNAs & Orderlies	175,044	190,565	2,146,306	11.26	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	4,212	4,697	66,188	14.09	9
10	Activity Assistants	10,543	11,329	115,070	10.16	10
11	Social Service Workers	9,023	9,577	127,532	13.32	11
12	Dietician					12
13	Food Service Supervisor	4,289	4,409	68,700	15.58	13
14	Head Cook					14
15	Cook Helpers/Assistants	47,501	50,702	511,531	10.09	15
16	Dishwashers					16
17	Maintenance Workers	7,008	8,084	123,980	15.34	17
18	Housekeepers	33,306	36,721	383,347	10.44	18
19	Laundry	18,936	21,244	226,552	10.66	19
20	Administrator	1,606	1,858	64,347	34.63	20
21	Assistant Administrator	2,476	2,836	82,861	29.22	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	14,030	15,511	249,971	16.12	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	9,244	10,070	131,339	13.04	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	438,262	475,750	\$ 7,287,774 *	\$ 15.32	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	1,886	\$ 58,492	1-3	35
36	Medical Director	1,000	60,000	9-3	36
37	Medical Records Consultant	134	3,616	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant	624	18,767	10a-3	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	3,644	\$ 140,875		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	12,171	\$ 486,870	10-3	50
51	Licensed Practical Nurses	355	12,785	10-3	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	12,526	\$ 499,655		53

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							
																	FY2006	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013
1	Painting and Decorating	Jan-Jul '04	\$ 1,320	3	\$ 440	\$ 220																		
2	Painting and Decorating	Aug-Oct '04	1,507	3	502	252																		
3	Painting and Decorating	Nov-Dec '04	2,768	3	923	461																		
4	Painting and Decorating	Jan-Jun '05	8,457	3	2,819	2,819	1,409																	
5	Painting and Decorating	Jul-Dec '05	2,504	3	835	835	417																	
6	Painting and Decorating	Jan-Jun '06	980	3	164	326	326	164																
7	Painting and Decorating	Jul-Dec '06	1,578	3	263	526	526	263																
8	Painting and Decorating	Jan-Jun '07	3,728	3		621	1,243	1,243	621															
9	Painting and Decorating	Jul-Dec '07	1,700	3		283	567	567	283															
10	Painting and Decorating	Jan-Jun '08	2,837	3			473	945	945	474														
11	Painting and Decorating	Jul-Dec '08	4,766	3			795	1,588	1,588	795														
12	Painting and Decorating	Feb-Jun '09	10,032	3				3,344	3,344	3,344														
13																								
14																								
15																								
16																								
17																								
18																								
19																								
20	TOTALS		\$ 42,177		\$ 5,946	\$ 6,343	\$ 5,756	\$ 8,114	\$ 6,781	\$ 4,613	\$	\$	\$											

Facility Name & ID Number Lake Shore Healthcare & Rehabilitation# 0035048Report Period Beginning: 1-Jan-2009Ending: 31-Dec-2009**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? No
If YES, give association name and amount. N/A
- (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? 7 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 98,512 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. \$ 171,368
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. \$ 46,746 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? None
d. Have vehicle usage logs been maintained? N/A
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
- (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.