

Facility Name & ID Number LAKEVIEW NURSING & REHABILITATION CENTRE

0026484 Report Period Beginning: 01/01/2009 Ending: 12/31/2009

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	178	Skilled (SNF)	178	64,970	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	178	TOTALS	178	64,970	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	3,400	243	8,838	12,481	8
9	SNF/PED					9
10	ICF	34,957	3,367	24	38,348	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	38,357	3,610	8,862	50,829	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 78.23%

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

0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.

(E.g., day care, "meals on wheels", outpatient therapy)

NONE

F. Does the facility maintain a daily midnight census?

YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?

YES NO

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES NO

I. On what date did you start providing long term care at this location?

Date started 08/15/81

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

YES Date 08/14/81 NO

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

YES NO If YES, enter number of beds certified 178 and days of care provided 8,319

Medicare Intermediary ADMINISTAR

IV. ACCOUNTING BASIS

ACCRAUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/2009 Fiscal Year: 12/31/09

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

Facility Name & ID Number LAKEVIEW NURSING & REHABILITATI # 0026484 Report Period Beginning: 01/01/2009 Ending: 12/31/2009

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	360,563	36,244	20,138	416,945		416,945	416,945			1
2	Food Purchase		349,332		349,332	(23,433)	325,899	325,899			2
3	Housekeeping	387,696	29,289		416,985		416,985	416,985			3
4	Laundry	73,495	20,855		94,350		94,350	94,350			4
5	Heat and Other Utilities			183,485	183,485		183,485	183,485			5
6	Maintenance	94,261	38,245	27,754	160,260		160,260	489	160,749		6
7	Other (specify):*			28,963	28,963		28,963		28,963		7
8	TOTAL General Services	916,015	473,965	260,340	1,650,320	(23,433)	1,626,887	489	1,627,376		8
	B. Health Care and Programs										
9	Medical Director			63,750	63,750		63,750	63,750			9
10	Nursing and Medical Records	3,069,934	264,633	38,901	3,373,468		3,373,468	3,373,468			10
10a	Therapy	496,301	330		496,631		496,631	496,631			10a
11	Activities	119,810	7,819	28,589	156,218		156,218	156,218			11
12	Social Services	103,653		2,984	106,637		106,637	106,637			12
13	CNA Training										13
14	Program Transportation			3,010	3,010		3,010		3,010		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	3,789,698	272,782	137,234	4,199,714		4,199,714		4,199,714		16
	C. General Administration										
17	Administrative	334,824		295,500	630,324		630,324	(295,500)	334,824		17
18	Directors Fees										18
19	Professional Services			190,965	190,965		190,965	4,169	195,134		19
20	Dues, Fees, Subscriptions & Promotions			99,048	99,048		99,048	(65,445)	33,603		20
21	Clerical & General Office Expenses	434,859	60,943	160,266	656,068		656,068	(84,340)	571,728		21
22	Employee Benefits & Payroll Taxes			1,085,941	1,085,941	23,433	1,109,374		1,109,374		22
23	Inservice Training & Education										23
24	Travel and Seminar			4,596	4,596		4,596		4,596		24
25	Other Admin. Staff Transportation			16,210	16,210		16,210		16,210		25
26	Insurance-Prop.Liab.Malpractice			151,846	151,846		151,846	14,853	166,699		26
27	Other (specify):*							7,868	7,868		27
28	TOTAL General Administration	769,683	60,943	2,004,372	2,834,998	23,433	2,858,431	(418,395)	2,440,036		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	5,475,396	807,690	2,401,946	8,685,032		8,685,032	(417,906)	8,267,126		29

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

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

V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE	SCHED REF	TOTAL
1	DIETARY	
	DIETITIAN CONSULTANT XVIII B 35-2	18,398
	REPAIRS & MAINTENANCE	1,740
		0
		20,138
3	HOUSEKEEPING	
		0
		0
		0
4	LAUNDRY	
	EQUIPMENT REPAIRS & MAINTENANCE	0
		0
		0
5	HEAT & OTHER UTILITIES	
	GAS HEAT	67,139
	ELECTRICITY	93,449
	WATER	22,897
	CABLE TV - LOBBY	0
		0
		183,485
6	MAINTENANCE	
	GROUNDS MAINTENANCE	2,250
	PAINTING & DECORATING	166
	BUILDING REPAIRS	0
	MAINTENANCE TRAVEL	0
	EQUIPMENT MAINTENANCE & REPAIR	8,755
	ELEVATOR MAINTENANCE & REPAIR	7,932
	OUTSIDE LABOR	0
	EXTERMINATING SERVICE	4,519
	FIRE SERVICE	4,132
		0
		0
		0
		0
		27,754
7	OTHER	
	SCAVENGER	26,621
	SECURITY SERVICE	2,342
		0
		0
		28,963
9	MEDICAL DIRECTOR	
	MEDICAL DIRECTOR FEES XVIII B 36-2	63,750
		63,750

LINE	SCHED REF	TOTAL
10	NURSING	
	CONTRACT NURSING XVIII C 53-2	
	LABORATORY & XRAY EXPENSE	0
	PURCHASED SERVICES	0
	PSYCHO-SOCIAL CONSULTANT XVIII B __-2	0
	RESTORATIVE NURSING CONSULTANT XVIII B 38-2	0
	MEDICAL RECORDS CONSULTANT XVIII B 37-2	5,968
	PHARMACY CONSULTANT XVIII B 39-2	0
	UTILIZATION REVIEW FEES XVIII B __-2	0
	PHYSICIANS XVIII B __-2	0
	PSYCHIATRIC XVIII B __-2	0
	RN CONSULTANT XVIII B 38-2	32,933
		0
		0
		38,901
10a	THERAPY	
	PHYSICAL THERAPY SERVICES	
	SPEECH THERAPY SERVICES	0
	OCCUPATIONAL THERAPY SERVICES	0
	REHABILITATION CONSULTANT XVIII B __-2	0
	PHYSICAL THERAPY CONSULTANT XVIII B 40-2	0
	OCCUPATIONAL THERAPY CONSULTA XVIII B 41-2	0
	RESPIRATORY THERAPY CONSULTAN XVIII B 42-2	0
	SPEECH THERAPY CONSULTANT XVIII B 43-2	0
		0
11	ACTIVITIES	
	CABLE TV - PATIENT ROOMS	26,001
	ACTIVITY REHAB CONSULTANT XVIII B 44-2	2,588
		0
		28,589
12	SOCIAL SERVICES	
	SOCIAL REHABILITATION SERVICES	
	SOCIAL REHABILITATION CONSULTAN XVIII B 45-2	0
	SOCIAL WORKER XVIII B 45-2	2,984
		0
		2,984
13	NURSE AIDE TRAINING	
	NURSE AIDE TRAINING COSTS XIII	0
		0

V.COST CENTER EXPENSES		PAGE 3 COLUMN 3 OTHER	
LINE	SCHED REF		TOTAL
14		PROGRAM TRANSPORTATION	
		PATIENT TRANSPORTATION	3,010
			0
17		ADMINISTRATIVE	
	XIX B	MANAGEMENT FEES	295,500
		DIRECTORS FEES	
18		DIRECTORS FEES	0
19		PROFESSIONAL SERVICES	
	XIX C	DATA PROCESSING	19,756
	XIX C	ADMINISTRATIVE CONSULTANTS	0
	XIX C	PROFESSIONAL FEES	171,209
			0
			190,965
20		FEES,SUBSCRIPTIONS,PROMOTIONS	
	VI 19 XIX F	ENTERTAINMENT & MARKETING	44,773
	VI 25 XIX F	ADV & PROMO-NON PATIENT RELATED	7,262
	XIX F	EMPLOYEE WANT ADS	9,641
	VI 20 XIX F	CONTRIBUTIONS	2,375
	XIX F	DUES & SUBSCRIPTIONS	17,043
	XIX F	LICENSES & PERMITS	2,300
	XIX F	PUBLIC RELATIONS-PATIENT RELATED	0
	VI 28 XIX F	ADVERTISING-YELLOW PAGES	4,965
	VI 17 XIX F	TRUST FEES / FRANCHISE TAX / ETC	0
	VI 20 XIX F	CONTRIBUTIONS - POLITICAL	6,070
	XIX F	HEALTH CARE WORKER BACKGROUND CHEC	2,200
	XIX F	PATIENT BACKGROUND CHECKS	2,419
			99,048
21		CLERICAL & GENERAL OFFICE EXPENSES	
		BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)	11,193
		EQUIPMENT REPAIR & MAINTENANCE	35,678
		OUTSIDE CLERICAL SERVICES	0
	VI 18	PENALTIES / OVERDRAFT CHARGES	61,347
		HOME OFFICE EXPENSE	0
		THEFT & DAMAGE LOSS	572
		TELEPHONE	47,865
		MESSENGER SERVICE	3,611
			0
			160,266

LINE	SCHED REF		TOTAL
22		EMPLOYEE BENEFITS & PAYROLL TAXES	
	XIX D	FICA TAXES	415,958
	XIX D	UNEMPLOYMENT COMPENSATION	51,550
	XIX D	WORKERS COMPENSATION INSURANC	116,656
	XIX D	HOSPITALIZATION INSURANCE	443,495
	XIX D	EMPLOYEE BENEFITS - OTHER	6,637
	XIX D	EMPLOYEE PHYSICAL EXAMS	722
	VI 21/XIX D	INSURANCE - EXECUTIVE LIFE	0
	XIX D	PENSION/PROFIT SHARING PLANS	42,363
	XIX D	CHICAGO HEAD TAX	8,560
			0
			1,085,941
23		INSERVICE TRAINING & EDUCATION	
		EDUCATION & SEMINARS	0
			0
24		TRAVEL & SEMINARS	
	XIX G	EDUCATION & SEMINARS	4,063
	XIX G	TRAVEL	533
			4,596
25		ADMIN. STAFF TRANSPORTATION	
		TRANSPORTATION - STAFF	16,210
			16,210
26		INSURANCE - PROP. LIAB & MALPRACTICE	
		GENERAL INSURANCE	151,846
			151,846
27		OTHER	
	VI 24	BAD DEBTS	0
			0

GRAND TOTAL COLUMN 3 OTHER **2,401,946**

LAKEVIEW NURSING & REHABILITATION CENTRE
SCHEDULES
12/31/2009

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

TOTAL FOOD PURCHASE	349,332
LESS SALES TAX	<u>0</u>
NET FOOD	349,332

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

TOTAL PATIENT CENSUS	50,829
TIME 3 MEALS PER DAY	<u>3</u>
TOTAL PATIENT MEALS	152,487

ADD # EMPLOYEE MEALS/DAY	30
TIME # DAYS	<u>365</u>
TOTAL EMPLOYEE MEALS	10,950

PATIENT MEALS	152,487
ADD EMPLOYEE MEALS	<u>10,950</u>
TOTAL MEALS/YEAR	163,437

NET FOOD	349,332
DIVIDE TOTAL MEALS/YEAR	<u>163,437</u>

COST PER MEAL	2.14
TIME EMPLOYEE MEALS	<u>10,950</u>
EMPLOYEE MEAL RECLASSIFICATION	23,433

=====

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			145,255	145,255		145,255	226,368	371,623			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			162,688	162,688		162,688	583,721	746,409			32
33	Real Estate Taxes							171,678	171,678			33
34	Rent-Facility & Grounds			954,354	954,354		954,354	(954,354)				34
35	Rent-Equipment & Vehicles			72,128	72,128		72,128		72,128			35
36	Other (specify):* RENT OFFICE			41,375	41,375		41,375	21,152	62,527			36
37	TOTAL Ownership			1,375,800	1,375,800		1,375,800	48,565	1,424,365			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		390,321	21,400	411,721		411,721		411,721			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			97,455	97,455		97,455		97,455			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		390,321	118,855	509,176		509,176		509,176			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	5,475,396	1,198,011	3,896,601	10,570,008		10,570,008	(369,341)	10,200,667			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	17,141	30		9
10	Interest and Other Investment Income	(12)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax		2		13
14	Non-Care Related Interest	(2,426)	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	(61,347)	21		18
19	Entertainment	(44,773)	20		19
20	Contributions	(8,445)	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		27		24
25	Fund Raising, Advertising and Promotional	(7,262)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(4,965)	20		28
29	Other-Attach Schedule SEE PAGE 5A	(89,430)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (201,519)		\$	30

BHF USE ONLY						
48		49		50		51
						52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(167,822)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (167,822)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B)	\$ (369,341)		37

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

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

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

STATE OF ILLINOIS
 LAKEVIEW NURSING & REHABILITATION CENTRE

ID# 0026484
 Report Period Beginning: 01/01/2009
 Ending: 12/31/2009

Sch. V Line
 Reference

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	DEFERRED MAINTENANCE	\$ 489	6	1
2	MARKETING SALARIES	(89,919)	21	2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32

33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total		(89,430)	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number LAKEVIEW NURSING & REHABILITATION CENTRE

0026484

Report Period Beginning:

01/01/2009

Ending:

12/31/2009

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	489	0	0	0	0	0	0	0	0	0	0	489	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	489	0	0	0	0	0	0	0	0	0	0	489	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	(295,500)	0	0	0	0	0	0	0	0	(295,500)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	4,169	0	0	0	0	0	0	0	0	4,169	19
20	Fees, Subscriptions & Promotions	(65,445)	0	0	0	0	0	0	0	0	0	0	(65,445)	20
21	Clerical & General Office Expenses	(151,266)	0	66,926	0	0	0	0	0	0	0	0	(84,340)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	14,853	0	0	0	0	0	0	0	0	0	14,853	26
27	Other (specify):*	0	0	7,868	0	0	0	0	0	0	0	0	7,868	27
28	TOTAL General Administration	(216,711)	14,853	(216,537)	0	(418,395)	28							
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(216,222)	14,853	(216,537)	0	(417,906)	29							

STATE OF ILLINOIS

Summary B

Facility Name & ID Number LAKEVIEW NURSING & REHABILITATION CENTRE

0026484

Report Period Beginning:

01/01/2009 Ending:

12/31/2009

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	17,141	209,227	0	0	0	0	0	0	0	0	0	226,368	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(2,438)	586,159	0	0	0	0	0	0	0	0	0	583,721	32
33	Real Estate Taxes	0	171,678	0	0	0	0	0	0	0	0	0	171,678	33
34	Rent-Facility & Grounds	0	(954,354)	0	0	0	0	0	0	0	0	0	(954,354)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	21,152	0	0	0	0	0	0	0	0	21,152	36
37	TOTAL Ownership	14,703	12,710	21,152	0	48,565	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)	(201,519)	27,563	(195,385)	0	0	0	0	0	0	0	0	(369,341)	45

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
SAM BOREK	50			BOREK & GOLDHIRSCH	WILMETTE	LAW FIRM
HILLARD GARLOVSKY	50			CONSULTANT FOR CORPORATE MGMT	WILMETTE	MGMT/CLERICAL
				735 W. DIVERSEY BUILDING, LLC	CHICAGO	REAL ESTATE

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

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

1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34 RENT	\$ 954,354	735 WEST DIVERSEY BUILDING, LLC		\$	\$(954,354)	1
2	V	30 SL DEPRECIATION		" " " " "		209,227	209,227	2
3	V	32 INTEREST		" " " " "		538,583	538,583	3
4	V	33 REAL ESTATE TAX		" " " " "		171,678	171,678	4
5	V	32 MORTGAGE INSURANCE		" " " " "		47,576	47,576	5
6	V	26 INSURANCE		" " " " "		14,853	14,853	6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 954,354			\$ 981,917	\$ * 27,563	14

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	17 MANAGEMENT FEES	\$ 295,500	CONSULTANT FOR CORPORATE MANAGEMENT		\$	\$ (295,500)
16	V	19 DATA PROCESSING				4,169	4,169
17	V	21 TOTAL OFFICE				66,926	66,926
18	V	27 EMPLOYEE BENEFITS				7,868	7,868
19	V	36 OFFICE AND STORAGE RENT				21,152	21,152
20	V						
21	V						
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		\$ 295,500			\$ 100,115	\$ * (195,385)

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

Facility Name & ID Number LAKEVIEW NURSING & REHABILITAT # 0026484 Report Period Beginning: 01/01/2009 Ending: 12/31/2009

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	SAM BOREK	PRESIDENT	ADMINISTRATIO	50.00		30	60.00	SALARY	\$ 157,082	17-1	1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 157,082		13

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

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

Facility Name & ID Number LAKEVIEW NURSING & REHABILITATION CENTRE # 0026484 Report Period Beginning: 01/01/2009 Ending: 2/31/2009

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

Name of Related Organization CONSULTANTS FOR CORPORATE MGMT
 Street Address 345 LAKE AVENUE
 City / State / Zip Code WILMETTE, IL 60091
 Phone Number (847) 784-8204
 Fax Number (847) 784-8248

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	19	DATA PROCESSING			\$ 4,169			\$ 4,169	1
2	21	TOTAL OFFICE			66,926	39,612		66,926	2
3	27	EMPLOYEE BENEFITS			7,868			7,868	3
4	36	OFFICE AND STORAGE RENT			21,152			21,152	4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 100,115	\$ 39,612		\$ 100,115	25

Facility Name & ID Number

LAKEVIEW NURSING & REHABILITATI

0026484

Report Period Beginning:

01/01/2009

Ending:

12/31/2009

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		8	9	10									
						Name of Lender	Related**				Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
							YES							NO	Original				Balance
	A. Directly Facility Related																		
	Long-Term																		
1	RELATED PARTY: 735 DIVERSEY BUILDING, LLC						\$	\$		\$	1								
2	CAMBRIDGE REALTY		X	MORTGAGE	\$77,801.29	05/04	10,055,500	9,490,548	05/39	5.6000	532,895	2							
3	LOAN COSTS		X	LOAN COSTS	W/O OVER LOAN		199,085	167,089			5,688	3							
4	PROVIDENCE CAPITAL		X	EQUIPMANT LEASE	\$23,085.00	11/07	950,226	507,119	12/11	8.6450	54,400	4							
5	MIP INSURANCE		X								47,576	5							
	Working Capital																		
6	BANK FINANCIAL	X		WORKING CAPITAL	DEMAND	12/07	2,412,203	2,258,604		PRIME+	94,930	6							
7	GLENVIEW STATE BANK		X	AUTO LOAN	\$276.94	05/09	13,270	11,789	04/14	9.4090	796	7							
8	MEPCO INSURANCE		X	INSURANCE FINANCE							10,136	8							
9	TOTAL Facility Related				\$101,163.23		\$ 13,630,284	\$ 12,435,149			\$ 746,421	9							
	B. Non-Facility Related*																		
10	IRS, IDR, ETC		X	LATE FEES							2,426	10							
11												11							
12												12							
13												13							
14	TOTAL Non-Facility Related						\$	\$			\$ 2,426	14							
15	TOTALS (line 9+line14)						\$ 13,630,284	\$ 12,435,149			\$ 748,847	15							

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 47,576 Line # 37-2

* 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

1. Real Estate Tax accrual used on 2008 report.	\$	176,609	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	\$	169,887	2
3. Under or (over) accrual (line 2 minus line 1).	\$	(6,722)	3
4. Real Estate Tax accrual used for 2009 report. (Detail and explain your calculation of this accrual on the lines below.)	\$	178,400	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)	\$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)	\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	\$	171,678	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2004	163,747	8
	2005	165,414	9
	2006	170,014	10
	2007	168,199	11
	2008	169,887	12

FOR BHF USE ONLY			
13	FROM R. E. TAX STATEMENT FOR 2008	\$	13
14	PLUS APPEAL COST FROM LINE 5	\$	14
15	LESS REFUND FROM LINE 6	\$	15
16	AMOUNT TO USE FOR RATE CALCULATION	\$	16

THE CURRENT YEAR REAL ESTATE TAX ACCRUEL IS BASED ON~ 105% PRIOR YEAR REAL ESTATE TAX BILL THE PAYMENT ON LINE 2 APPLIED TO THE 2008 TAX BILL

NOTES:

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

4.	_____	_____	\$ _____	\$ _____
5.	_____	_____	\$ _____	\$ _____
6.	_____	_____	\$ _____	\$ _____
7.	_____	_____	\$ _____	\$ _____
8.	_____	_____	\$ _____	\$ _____
9.	_____	_____	\$ _____	\$ _____
10.	_____	_____	\$ _____	\$ _____
		TOTALS	\$ <u>169,886.95</u>	\$ <u>169,886.95</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 and 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 2008 tax bills which were listed in Section A to this statement. Be sure to use the 2008 tax bill which is normally paid during 2009.

PLEASE NOTE: *Payment information from the Internet* or otherwise is *not considered acceptable tax bill documentation* . Facilities located in Cook County are required to provide copies of their original **second installment tax bill.**

X. BUILDING AND GENERAL INFORMATION:

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

C. Does the Operating Entity? (a) Own the Facility (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.
 (Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? (a) Own the Equipment (b) Rent equipment from a Related Organization. (c) Rent equipment from Completely Unrelated Organization.
 (Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

N/A

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

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

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

XI. OWNERSHIP COSTS:

A. Land.

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

Facility Name & ID Number LAKEVIEW NURSING & REHABILITATION CENTRE

0026484

Report Period Beginning:

01/01/2009

Ending:

12/31/2009

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		
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	178	2001		\$ 5,022,332	\$ 128,778	39	\$ 128,778	\$	\$ 1,132,323	4
5										5
6										6
7										7
8										8
Improvement Type**										
9	LEASEHOLD IMPROVEMENTS		1982	2,850					2,850	9
10	LEASEHOLD IMPROVEMENTS		1983	2,500		15			2,500	10
11	LEASEHOLD IMPROVEMENTS		1985	2,312		10			2,312	11
12	LEASEHOLD IMPROVEMENTS		1985	3,200		20			3,200	12
13	LEASEHOLD IMPROVEMENTS		1987	29,042	922	20		(922)	29,042	13
14	LEASEHOLD IMPROVEMENTS		1987	8,647	275	31.5	275		6,046	14
15	LEASEHOLD IMPROVEMENTS		1988	13,520	429	31.5	429		9,358	15
16	LEASEHOLD IMPROVEMENTS		1989	17,460	554	5		(554)	17,460	16
17	LEASEHOLD IMPROVEMENTS		1989	6,534	207	15		(207)	6,534	17
18	LEASEHOLD IMPROVEMENTS		1990	20,612	654	31.5	654		13,080	18
19	LEASEHOLD IMPROVEMENTS		1991	40,916	1,299	31.5	1,299		24,031	19
20	LEASEHOLD IMPROVEMENTS		1992	40,819	1,296	31.5	1,296		22,748	20
21	LEASEHOLD IMPROVEMENTS		1993	10,482	333	31.5	333		5,606	21
22	LEASEHOLD IMPROVEMENTS		1993	16,965	435	39	435		7,043	22
23	LEASEHOLD IMPROVEMENTS		1994	9,602	246	39	246		3,865	23
24	ROOF REPAIR		1995	3,188	82	39	82		1,194	24
25	SHOWER RECONSTRUCTION		1995	7,775	200	39	200		2,802	25
26	SHOWER ROOMS RENOVATION		1996	35,634	914	39	914		12,423	26
27	OFFICE CONSTRUCTION		1996	4,647	119	39	119		1,600	27
28	ELECTRIC SLIDING DOOR		1996	1,380	35	39	35		461	28
29	BRICKWORK/TUCKPOINT		1997	1,680	43	39	43		546	29
30	PARKING LOT		1997	1,900	49	39	49		721	30
31	CLOSET WORK		1997	800	20	39	20		257	31
32	CONSULTING AND INSTALL FIREDOORS		1997	23,621	606	39	606		7,343	32
33	FIRE ALARM PANEL		1998	3,500	90	39	90		1,061	33
34	ROOF EXHAUST FANS, INSTALLATION FIRE DAMPTERS		1998	20,698	531	39	531		6,214	34
35	FRONT PORCH ENTRANCE, ONE MARQUEE CANOPY		1998	2,247	57	39	57		661	35
36	SMOKE DAMPERS		1998	1,669	43	39	43		489	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 LAKEVIEW NURSING & REHABILITATION CENTRE

0026484

Report Period Beginning:

01/01/2009 Ending: 12/31/2009

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	WALK IN FREEZER-NEW CONDENSING UNIT	1998	\$ 5,546	\$ 142	39	\$ 142		\$ 1,592	37
38	CEILING & LIGHT FIXTURES, ELECTRICAL	1998	30,226	775	39	775		8,559	38
39	CAFETERIAS - 1ST AND 3RD FLOOR	1999	3,000	77	39	77		837	39
40	LIGHTING, ELECTRICAL WORK, INSTALL CABLE	1999	27,482	705	39	705		7,644	40
41	DOORS REPAIR & PAINT-1ST,2ND AND 3RD FLOOR	1999	25,070	643	39	643		6,858	41
42	PLUMBING ROUGH	1999	10,300	264	39	264		2,827	42
43	PAINT WORK-1ST,END,3RD FLOOR, BASEMENT	1999	21,014	539	39	539		5,637	43
44	WALLCOVERING, CARPET TILES	1999	55,627	1,426	39	1,426		14,959	44
45	GENERATOR EXHAUST PIPE	1999	2,300	59	39	59		627	45
46	HANDRAILS-1ST,2ND,3RD FLOOR, BASEMENT	1999	24,340	624	39	624		6,602	46
47	ALARM SYSTEM	1999	107,758	2,763	39	2,763		29,767	47
48	DINING ROOM - 2ND AND 3RD FLOOR	1999	12,206	313	39	313		3,276	48
49	SHOWER AND FRONT STOOP REPAIR	1999	4,300	110	39	110		1,144	49
50	WINDOWS, CLOSETS, EXTERIOR	1999	4,415	113	39	113		1,091	50
51	INSTALLATION OF THE FIRE DAMPERS	1999	5,880	151	39	151		1,642	51
52	PLEATED SHADES	2000	949		20	47	47	470	52
53	CANVAS CANOPY	2000	3,996	102	39	102		1,001	53
54	INSTALLATION OF COOLING TOWER	2000	24,450	627	39	627		6,086	54
55	ALARM SYSTEM - ADDITIONAL PROTECTION	2000	1,970	51	39	51		495	55
56	DIALYSIS ROOM EXTRA CIRCUITS	2000	1,983	51	39	51		495	56
57	MICROLIGHT DETECTORS	2000	3,800	97	39	97		922	57
58	REPAIR DRYWALL	2000	3,744	96	39	96		889	58
59	ELECTRICAL PANEL FOR DIALYSIS CENTER	2000	2,380	61	39	61		562	59
60	INSTALLED 9 DOOR HOLDERS	2000	3,465	89	39	89		812	60
61	REMODELING NEW NORTHFIELD OFFICE	2001	3,440	88	39	88		789	61
62	TWO PASSENGER ELEVATOR	2001	84,711	2,172	39	2,172		18,191	62
63	TUCKPOINTING	2001	3,160	81	39	81		665	63
64	REPAVE DRIVEWAY & PARKING LOT	2001	7,000	179	39	179		1,493	64
65	ELECTRICAL WORK	2001	11,922	306	39	306		2,497	65
66	ROOF REPAIR	2001	7,945	204	39	204		1,689	66
67	PAINTING, WALLPAPERING, DRYWALL	2001	42,598	1,092	39	1,092		10,901	67
68	BACKUP GENERATOR	2002	6,375	163	39	163		1,298	68
69	ELECTRICAL WORK	2002	5,000	128	39	128		1,019	69
70	TOTAL (lines 4 thru 69)		\$ 5,914,884	\$ 152,508		\$ 150,872	\$ (1,636)	\$ 1,467,106	70

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

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 5,914,884	\$ 152,508		\$ 150,872	\$ (1,636)	\$ 1,467,106	1
2	ROOF & GUTTER REPAIR	2002	7,000	180	39	180		1,432	2
3	FLOORING & TILE IN CAFETERIA	2002	5,368	138	20	268	130	2,144	3
4	REPAIR DRIVEWAY & PARKING LOT	2002	3,300	85	15	220	135	1,760	4
5	CABINET INSTALLATION IN MAINTENANCE ROOM	2002	3,200	82	39	82		639	5
6	CARPETING INSTALLATION IN WAITING AREA	2002	3,561	91	20	178	87	1,424	6
7	REPLACE CABLE IN ELEVATOR	2002	5,800	149	39	149		1,148	7
8	BATHROOM SHOWER	2003	8,075	207	39	207		1,354	8
9	BOILER RE-TUBING	2003	21,850	560	39	560		3,570	9
10	CARPETING AND SHADES	2003	5,186		20	259	259	1,813	10
11	PLUMBING REVISIONS FOR DIALYSIS LOOP PIPING	2004	14,993	545	27.5	545		2,975	11
12	SPRINKLER SYSTEM & FIRE ALARM REPAIR	2005	6,556	238	27.5	238		1,101	12
13	ASPHALT PAVEMENT	2006	3,859	257	15	257		1,028	13
14	SLIDING DOORS & CIRCUIT TO A NEW DOOR OPENER	2006	5,890	214	27.5	214		740	14
15	BUILDING RENOVATION AND REMODELING:	2006	685,986	24,945	27.5	24,945		86,268	15
16	BUIL-IN WARDROBE,WALLCOVERING, TILES, FLOORING,								16
17	1-ST FLOOR LOBBY, DINING ROOM, PHYSICAL THERAPY ROOM,								17
18	NEW CELLINGS, CUSTOM NURSING STATION, BEAUTY SHOP,								18
19	ADMISSION AND ACCOUNTING OFFICE, WALL MOUNTED								19
20	FOUNTAIN, RESIDENT BATHROOM, ACCENT WALL FOR								20
21	CONFERENCE ROOM								21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 6,695,508	\$ 180,199		\$ 179,174	\$ (1,025)	\$ 1,574,502	34

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

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 6,695,508	\$ 180,199		\$ 179,174	\$ (1,025)	\$ 1,574,502	1
2	735 WEST DIVERSEY BUILDING LLC								2
3	REPLACE 100 TON CHILLER	2007	114,700	11,470	10	11,470			3
4	SEAL COAT ASPHALT RAMP, TUCKPOINTING	2007	10,500	1,050	10	1,050			4
5	INSTALLED TWO OUTDOOR WALL SCONCE, LANTERN	2007	5,243	524	10	524			5
6	INSTALLATION OF ADDT'L SMOKE DETECTOR	2007	3,650	365	10	365			6
7	REPLACE HYDRAULIC CYLINDER FOR ELEVATOR	2007	64,756	6,476	10	6,476			7
8	INSTALL NEW SET OF ROLLER GUIDES ON ELEVATOR	2007	3,169	317	10	317			8
9	DIALYSIS ROOM - FLOORING	2008	3,518	352	10	352			9
10	ELEVATOR-REPLACE DELTA RELAY IN CONTROLLER	2008	2,946	294	10	294			10
11	INSTALL REMOTE ANNUNCIATER	2008	4,033	403	10	403			11
12	CHILLER-INSTALL VENTILATION & MONITORING SYSTE	2008	20,223	2,022	10	2,022			12
13	REPAIR BRICK AND FURNISH 1100 NEW UTILITY BRICK	2009	24,475	716	10	716			13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 6,952,721	\$ 204,188		\$ 203,163	\$ (1,025)	\$ 1,574,502	34

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

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 1,794,455	\$ 84,643	\$ 108,395	\$ 23,752	3-15	\$ 487,350	71
72	Current Year Purchases	5,027	1,006	251	(755)	10	251	72
73	Fully Depreciated Assets	793,340					793,340	73
74	RELATED PARTY DEPRECIATION		56,460	56,460				74
75	TOTALS	\$ 2,592,822	\$ 142,109	\$ 165,106	\$ 22,997		\$ 1,280,941	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	ADMINISTRATIVE	1999 BLAZER	1999	\$ 34,882	\$ 1,775	\$	\$ (1,775)	5	\$ 34,882	76
77	ADMINISTRATIVE	1999 MERSEDES	2001	53,242	1,775		(1,775)	5	53,242	77
78	ADMINISTRATIVE	2004 LEXUS	2004	43,476	1,675		(1,675)	5	43,476	78
79	ADMINISTRATIVE	2007 SUBARU IMPREZA	2009	16,770	2,960	3,354	394	5	3,354	79
80	TOTALS			\$ 148,370	\$ 8,185	\$ 3,354	\$ (4,831)		\$ 134,954	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)	\$ 10,251,950	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 354,482	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 371,623	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 17,141	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 2,990,397	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A - RELATED PARTY

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

If NO, see instructions. YES NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

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

Fiscal Year Ending Annual Rent

12. _____ \$ _____

13. _____ \$ _____

14. _____ \$ _____

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: \$ 47,019 Description: SEE SCHEDULE ATTACHED

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	ADMINISTRATIVE	2009 PORSCHE	\$ #####	\$ 15,173	17
18	DON	2005 JEEP CHEROKEE	398.30	4,910	18
19	ADMINISTRATIVE	2004 TOYOTA WAGON	614.52	5,026	19
20					20
21	TOTAL		\$ #####	\$ 25,109	21

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

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

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

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	1 Schedule V Line & Column Reference	2		3	4		5	6	7	8
			Staff		Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service			Units	Cost				
1	Licensed Occupational Therapist	39-3	hrs	\$		\$					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			21,400				21,400	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 prescrpts					243,614		243,614	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs								10
11	Academic Education		hrs								11
12	Other (specify):										12
13	Radiology, Respiratory, Laboratory Other (specify): <u>Rentals, Dialysis</u>	39-2 39-2						57,752 88,955		57,752 88,955	13
14	TOTAL			\$		\$ 21,400		\$ 390,321		\$ 411,721	14

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

Facility Name & ID Number LAKEVIEW NURSING & REHABILITATION CENTRE # 0026484 Report Period Beginning: 01/01/2009 Ending: 12/31/2009
 XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2009 (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	\$ 97,707	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance <u>100,000</u>)	2,494,311		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	140,436		6
7	Other Prepaid Expenses	18,002		7
8	Accounts Receivable (owners or related parties)	1,079,046		8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 3,829,502	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	1,673,176		15
16	Equipment, at Historical Cost	1,947,852		16
17	Accumulated Depreciation (book methods)	(2,203,376)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,417,652	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 5,247,154	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 1,667,001	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	29,012		28
29	Short-Term Notes Payable	1,183,604		29
30	Accrued Salaries Payable	182,423		30
31	Accrued Taxes Payable (excluding real estate taxes)	1,055,025		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 4,117,065	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	518,908		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)	\$ 518,908	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 4,635,973	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 611,181	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 5,247,154	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,482,290	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,482,290	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(871,109)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (871,109)	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)	\$ 611,181	24 *

* This must agree with page 17, line 47.

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required

classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

		1	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 9,370,066	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 9,370,066	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	328,194	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 328,194	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	12	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 12	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	VENDING COMMISSIONS	2,146	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 2,146	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 9,700,418	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	1,650,320	31
32	Health Care	4,199,714	32
33	General Administration	2,834,998	33
B. Capital Expense			
34	Ownership	1,375,800	34
C. Ancillary Expense			
35	Special Cost Centers	411,721	35
36	Provider Participation Fee	97,455	36
D. Other Expenses (specify):			
37	OUT-OF-PERIOD EXPENSES		37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 10,570,008	40
41	Income before Income Taxes (line 30 minus line 40)**	(869,590)	41
42	Income Taxes	(1,519)	42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (871,109)	43

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? YES If not, please attach a reconciliation.

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

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

Facility Name & ID Number LAKEVIEW NURSING & REHABILITATION CENTRE

0026484

Report Period Beginning: 01/01/2009

Ending: 12/31/2009

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	2,045	2,102	\$ 100,604	\$ 47.86	1
2	Assistant Director of Nursing	1,608	1,862	73,232	39.33	2
3	Registered Nurses	21,783	23,319	771,000	33.06	3
4	Licensed Practical Nurses	39,902	42,129	993,739	23.59	4
5	CNAs & Orderlies	91,490	96,981	968,454	9.99	5
6	CNA Trainees					6
7	Licensed Therapist	8,576	9,595	331,542	34.55	7
8	Rehab/Therapy Aides	9,610	10,334	164,759	15.94	8
9	Activity Director	1,936	2,104	31,015	14.74	9
10	Activity Assistants	9,627	10,208	88,795	8.70	10
11	Social Service Workers	4,991	5,521	103,653	18.77	11
12	Dietician					12
13	Food Service Supervisor	1,960	2,072	23,570	11.38	13
14	Head Cook					14
15	Cook Helpers/Assistants	27,915	30,087	336,993	11.20	15
16	Dishwashers					16
17	Maintenance Workers	4,208	4,521	94,261	20.85	17
18	Housekeepers	32,476	35,565	387,696	10.90	18
19	Laundry	6,572	7,636	73,495	9.62	19
20	Administrator	2,168	2,522	145,396	57.65	20
21	Assistant Administrator	1,112	1,252	32,346	25.84	21
22	Other Administrative	2,072	2,080	157,082	75.52	22
23	Office Manager	2,048	2,080	79,049	38.00	23
24	Clerical	17,230	18,272	265,891	14.55	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,811	1,915	33,880	17.69	31
32	Other Health C: <u>SEE ATTACHED</u>	6,416	6,516	129,025	19.80	32
33	Other(specify) <u>MARKETING</u>	3,564	3,630	89,919	24.77	33
34	TOTAL (lines 1 - 33)	301,120	322,303	\$ 5,475,396 *	\$ 16.99	34

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

** See instructions.

B. CONSULTANT SERVICES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference		
35	Dietary Consultant	Monthly	\$ 18,398	1-3	35
36	Medical Director	Monthly	63,750	9-3	36
37	Medical Records Consultant	Monthly	5,968	10-3	37
38	Nurse Consultant	Monthly	32,933	10-3	38
39	Pharmacist Consultant		0	10-3	39
40	Physical Therapy Consultant		0	10a-3	40
41	Occupational Therapy Consultant		0	10a-3	41
42	Respiratory Therapy Consultant		0	10a-3	42
43	Speech Therapy Consultant		0	10a-3	43
44	Activity Consultant	52	2,588	11-3	44
45	Social Service Consultant	58	2,984	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	110	\$ 126,621		49

C. CONTRACT NURSES

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

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
MICHAEL ELKES	ADMINISTRATOR	0	\$ 52,511	Workers' Compensation Insurance	\$ 116,656	IDPH License Fee	\$ 2,200	
TED O'BRIEN	ADMINISTRATOR	0	92,885	Unemployment Compensation Insurance	51,550	Advertising: Employee Recruitment	9,641	
BARBARA GONZALES	ASST ADMIN	50	32,346	FICA Taxes	415,958	Health Care Worker Background Check	2,200	
SAM BOREK	PRESIDENT		157,082	Employee Health Insurance	443,495	(Indicate # of checks performed <u>220</u>)		
				Employee Meals	23,433	<u>Patient Background Checks</u> <u>222</u>	2,419	
				Illinois Municipal Retirement Fund (IMRF)*		<u>TRUST/FRANCHISE/CONTRIB/ETC</u>	8,445	
				<u>EMPLOYEE BENEFITS - OTHER</u>	6,637	<u>MARKETING/ADV/PROMO</u>	57,000	
				<u>EMPLOYEE PHYSICAL EXAMS</u>	722	<u>LICENSES/DUES/SUBSCRIPTIONS</u>	17,143	
				<u>PENSION/PROFIT SHARING PLANS</u>	42,363	<u>MGMT CO ALLOC</u>		
				<u>CHICAGO HEAD TAX</u>	8,560	<u>TRUST/FRANCHISE/CONTRIB/ETC</u>	(8,445)	
				<u>INSURANCE - EXECUTIVE LIFE</u>	0	Less: Public Relations Expense	(44,773)	
				<u>INSURANCE - EXECUTIVE LIFE VI 21</u>	0	Non-allowable advertising	(7,262)	
						Yellow page advertising	(4,965)	
TOTAL (agree to Schedule V, line 17, col. 1)			\$ 334,824	TOTAL (agree to Schedule V, line 22, col.8)	\$ 1,109,374	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 33,603	
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Description			Amount	Description	Line #	Amount	Description	Amount
CONSULTANTS FOR CORPORATE MANAGEMENT			\$ 295,500				Out-of-State Travel	\$
							In-State Travel	533
							Seminar Expense	4,063
							Entertainment Expense	()
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 295,500	TOTAL		\$	TOTAL (agree to Sch. V, line 24, col. 8)	\$ 4,596
C. Professional Services								
Vendor/Payee	Type		Amount					
			\$					
<u>SEE SCHEDULE ATTACHED</u>			190,965					
TOTAL (agree to Schedule V, line 19, column 3)			\$ 190,965					
(If total legal fees exceed \$5,000, attach copy of invoices.)								

* Attach copy of IMRF notifications

**See instructions.

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

(See instructions.)

1	2	3	4	5	6	7	8	9	10	11	12	13
Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	FY2006	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014
1	PAINT/DECORATING	2006	\$ 2,930	3 YRS	\$ 489	\$ 976	\$ 976	\$ 489	\$	\$	\$	\$
2												
3												
4												
5												
6												
7												
8												
9												
10												
11												
12												
13												
14												
15												
16												
17												
18												
19												
20	TOTALS		\$ 2,930		\$ 489	\$ 976	\$ 976	\$ 489	\$	\$	\$	\$

Facility Name & ID Number LAKEVIEW NURSING & REHABILITATION CENTRE

0026484

Report Period Beginning: 01/01/2009 Ending: 12/31/2009

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? YES
If YES, give association name and amount. IL COUNCIL ON LONG TERM CARE \$ 8,882
- (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. \$ 509 Line 10-2
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? NO
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? _____ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 97,455
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. \$ 23,433 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: _____
- (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.