



Facility Name & ID Number Lakewood Nursing & Rehab Center

# 0046169 Report Period Beginning: 01/01/09 Ending: 12/31/09

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>131</u>	Skilled (SNF)	<u>131</u>	<u>47,815</u>	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	<u>131</u>	TOTALS	<u>131</u>	<u>47,815</u>	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	<u>22,414</u>	<u>8,013</u>	<u>10,862</u>	<u>41,289</u>	8	
9	SNF/PED					9	
10	ICF					10	
11	ICF/DD					11	
12	SC					12	
13	DD 16 OR LESS					13	
14	TOTALS	<u>22,414</u>	<u>8,013</u>	<u>10,862</u>	<u>41,289</u>	14	

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 86.35%

D. How many bed-hold days during this year were paid by the Department? 6 (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 2/1/2003

J. Was the facility purchased or leased after January 1, 1978?  
YES  Date 2/1/2003 NO

K. Was the facility certified for Medicare during the reporting year?  
YES  NO  If YES, enter number of beds certified 131 and days of care provided 10,060

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL  MODIFIED CASH\*  CASH\*

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

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

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

Facility Name & ID Number Lakewood Nursing & Rehab Center # 0046169 Report Period Beginning: 01/01/09 Ending: 12/31/09

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>A. General Services</b>										
1	Dietary	281,343	36,577	13,368	331,288		331,288	2,639	333,927		1
2	Food Purchase		216,615		216,615		216,615	(1,385)	215,230		2
3	Housekeeping	176,438	40,026		216,464		216,464	(3,147)	213,317		3
4	Laundry	44,286	18,920		63,206		63,206	(1,000)	62,206		4
5	Heat and Other Utilities			169,618	169,618		169,618	1,916	171,534		5
6	Maintenance	129,364	351	199,203	328,918		328,918	12,205	341,123		6
7	Other (specify):*							1,670	1,670		7
8	<b>TOTAL General Services</b>	631,431	312,489	382,189	1,326,109		1,326,109	12,898	1,339,007		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			10,800	10,800		10,800		10,800		9
10	Nursing and Medical Records	2,752,633	180,008	82,676	3,015,317		3,015,317	12,150	3,027,467		10
10a	Therapy	223,739			223,739		223,739	27,808	251,547		10a
11	Activities	121,458	18,705		140,163		140,163		140,163		11
12	Social Services	166,007	2,400	11,388	179,795		179,795	7,423	187,218		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*							7,061	7,061		15
16	<b>TOTAL Health Care and Programs</b>	3,263,837	201,113	104,864	3,569,814		3,569,814	54,442	3,624,256		16
	<b>C. General Administration</b>										
17	Administrative	146,707			146,707		146,707	42,627	189,334		17
18	Directors Fees										18
19	Professional Services			365,916	365,916		365,916	(307,848)	58,068		19
20	Dues, Fees, Subscriptions & Promotions			34,427	34,427		34,427	(16,984)	17,443		20
21	Clerical & General Office Expenses	139,232	20,748	265,591	425,571		425,571	(94,017)	331,554		21
22	Employee Benefits & Payroll Taxes			644,736	644,736		644,736	(8,381)	636,355		22
23	Inservice Training & Education										23
24	Travel and Seminar			6,492	6,492		6,492	866	7,358		24
25	Other Admin. Staff Transportation			5,726	5,726		5,726	385	6,111		25
26	Insurance-Prop.Liab.Malpractice			152,291	152,291		152,291	(19,097)	133,194		26
27	Other (specify):*							25,287	25,287		27
28	<b>TOTAL General Administration</b>	285,939	20,748	1,475,179	1,781,866		1,781,866	(377,162)	1,404,704		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	4,181,207	534,350	1,962,232	6,677,789		6,677,789	(309,822)	6,367,967		29

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name &amp; ID Number

Lakewood Nursing &amp; Rehab Center

#0046169

Report Period Beginning:

01/01/09

Ending:

12/31/09

## 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	
	<b>D. Ownership</b>											
30	Depreciation			117,844	117,844		117,844	378,425	496,269			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							337,433	337,433			32
33	Real Estate Taxes			82,962	82,962		82,962	1,854	84,816			33
34	Rent-Facility & Grounds			526,797	526,797		526,797	(522,360)	4,437			34
35	Rent-Equipment & Vehicles			5,283	5,283		5,283	2,055	7,338			35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			732,886	732,886		732,886	197,407	930,293			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		766,596	986,311	1,752,907		1,752,907	(36,435)	1,716,472			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			71,723	71,723		71,723		71,723			42
43	Other (specify):*			171	171		171	(171)				43
44	<b>TOTAL Special Cost Centers</b>		766,596	1,058,205	1,824,801		1,824,801	(36,606)	1,788,195			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	4,181,207	1,300,946	3,753,323	9,235,476		9,235,476	(149,021)	9,086,455			45

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

SEE ACCOUNTANTS' COMPILATION REPORT

**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	(1,422)	02		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	133,471	30		9
10	Interest and Other Investment Income	(93,937)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(415)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)	(300)	10		16
17	Non-Care Related Fees				17
18	Fines and Penalties	(27,801)	21		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(74,061)	21		24
25	Fund Raising, Advertising and Promotional	(18,468)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(100)	21		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(155,201)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (238,234)		\$	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)	89,213		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ 89,213		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ (149,021)		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	<b>TOTAL (C): (sum of lines 38-46)</b>			\$		47

BHF USE ONLY							
48		49		50		51	

SEE ACCOUNTANTS' COMPILATION REPORT

Lakewood Nursing & Rehab Center

ID# 0046169

Report Period Beginning: 01/01/09

Ending: 12/31/09

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Theft Loss	\$ (751)	21	1
2	Account Collections Expenses	(461)	21	2
3	Child Support Income	(200)	21	3
4	Jury Duty Income	(37)	10	4
5	Additional R&M	32	06	5
6	Annual Report	(250)	20	6
7	Prior Period Liability Insurance	(20,147)	26	7
8	Prior Period Nursing Expenses	(508)	10	8
9	Marketing Expense	(171)	43	9
10	Non-Allowable Office Expense	(111,331)	21	10
11	Building Company Bank Charges	(632)	21	11
12	Building Company Amortization	(18,292)	31	12
13	Non-Allowable Legal	(2,453)	19	13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	<b>Total</b>	(155,201)		49

Lakewood Nursing & Rehab Center

ID# 0046169

Report Period Beginning: 01/01/09

Ending: 12/31/09

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
50		\$	1
51			2
52			3
53			4
54			5
55			6
56			7
57			8
58			9
59			10
60			11
61			12
62			13
63			14
64			15
65			16
66			17
67			18
68			19
69			20
70			21
71			22
72			23
73			24
74			25
75			26
76			27
77			28
78			29
79			30
80			31
81			32
82			33
83			34
84			35
85			36
86			37
87			38
88			39
89			40
90			41
91			42
92			43
93			44
94			45
95			46
96			47
97			48
98			49

## STATE OF ILLINOIS

Summary A

Facility Name & ID Number Lakewood Nursing & Rehab Center# 0046169

Report Period Beginning:

01/01/09

Ending:

12/31/09

## 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			203		3,526	(4)				(1,086)		2,639	1
2	Food Purchase	(1,837)		452									(1,385)	2
3	Housekeeping			422		46	(3,615)						(3,147)	3
4	Laundry						(1,000)						(1,000)	4
5	Heat and Other Utilities			1,730		111					75		1,916	5
6	Maintenance	32		2,684	6,576	14	(294)		3,135		58		12,205	6
7	Other (specify):*				1,159	511							1,670	7
8	<b>TOTAL General Services</b>	<b>(1,805)</b>		<b>5,491</b>	<b>7,735</b>	<b>4,208</b>	<b>(4,913)</b>		<b>3,135</b>		<b>(953)</b>		<b>12,898</b>	<b>8</b>
	<b>B. Health Care and Programs</b>													
9	Medical Director													9
10	Nursing and Medical Records	(845)				24,001	(11,006)						12,150	10
10a	Therapy					1,380				26,428			27,808	10a
11	Activities													11
12	Social Services					7,423							7,423	12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*					7,061							7,061	15
16	<b>TOTAL Health Care and Programs</b>	<b>(845)</b>				<b>39,865</b>	<b>(11,006)</b>			<b>26,428</b>			<b>54,442</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative			1,980	7,180	31,307					2,160		42,627	17
18	Directors Fees													18
19	Professional Services	(2,453)		(234,295)		(71,352)			172		80		(307,848)	19
20	Fees, Subscriptions & Promotions	(18,718)		1,695		6					33		(16,984)	20
21	Clerical & General Office Expenses	(215,337)	632	13,872	107,995	7,021			(10,814)		2,614		(94,017)	21
22	Employee Benefits & Payroll Taxes				(3,220)	(4,785)	(376)						(8,381)	22
23	Inservice Training & Education													23
24	Travel and Seminar			53		813							866	24
25	Other Admin. Staff Transportation			309					14		62		385	25
26	Insurance-Prop.Liab.Malpractice	(20,147)		680		40			177		153		(19,097)	26
27	Other (specify):*				18,905	5,439					943		25,287	27
28	<b>TOTAL General Administration</b>	<b>(256,655)</b>	<b>632</b>	<b>(215,706)</b>	<b>130,860</b>	<b>(31,511)</b>	<b>(376)</b>		<b>(10,451)</b>		<b>6,045</b>		<b>(377,162)</b>	<b>28</b>
29	<b>TOTAL Operating Expense</b> (sum of lines 8,16 & 28)	<b>(259,305)</b>	<b>632</b>	<b>(210,215)</b>	<b>138,595</b>	<b>12,562</b>	<b>(16,295)</b>		<b>(7,316)</b>	<b>26,428</b>	<b>5,092</b>		<b>(309,822)</b>	<b>29</b>

## STATE OF ILLINOIS

Summary B

Facility Name & ID Number Lakewood Nursing & Rehab Center# 0046169

Report Period Beginning:

01/01/09

Ending:

12/31/09

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	133,471	223,384	3,467		768			17,177		158		378,425	30
31	Amortization of Pre-Op. & Org.	(18,292)	18,292											31
32	Interest	(93,937)	368,126	50,964		9,276			3,004				337,433	32
33	Real Estate Taxes			1,672		182							1,854	33
34	Rent-Facility & Grounds		(525,965)	2,900							705		(522,360)	34
35	Rent-Equipment & Vehicles			2,048							7		2,055	35
36	Other (specify):*													36
37	<b>TOTAL Ownership</b>	<b>21,242</b>	<b>83,837</b>	<b>61,051</b>		<b>10,226</b>			<b>20,181</b>		<b>870</b>		<b>197,407</b>	<b>37</b>
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers						(7,691)		(31,860)	7,390	(4,274)		(36,435)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(171)											(171)	43
44	<b>TOTAL Special Cost Centers</b>	<b>(171)</b>					<b>(7,691)</b>		<b>(31,860)</b>	<b>7,390</b>	<b>(4,274)</b>		<b>(36,606)</b>	<b>44</b>
	<b>GRAND TOTAL COST</b>													
45	(sum of lines 29, 37 & 44)	(238,234)	84,469	(149,164)	138,595	22,788	(23,987)		(18,995)	33,818	1,688		(149,021)	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
See Attached		See Attached		See Attached	See Attached	
				Lakewood Plainfield Property LLC		Building Co,

**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	34 Rental Income	\$ 525,965	Lakewood Plainfield Property LLC	100.00%	\$	(525,965)	1
2	V	33 Real Estate Taxes	82,962	Lakewood Plainfield Property LLC	100.00%	82,962		2
3	V	32 Interest Income	57,339	Lakewood Plainfield Property LLC	100.00%		(57,339)	3
4	V	21 Bank Charges		Lakewood Plainfield Property LLC	100.00%	632	632	4
5	V	30 Depreciation		Lakewood Plainfield Property LLC	100.00%	223,384	223,384	5
6	V	31 Amortization		Lakewood Plainfield Property LLC	100.00%	18,292	18,292	6
7	V	32 Interest Expense		Lakewood Plainfield Property LLC	100.00%	425,465	425,465	7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 666,266			\$ 750,735	\$ * 84,469	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	01 Dietary	\$	Extended Care Consulting, LLC	100.00%	\$ 203	\$	203	15
16	V	02 Food		Extended Care Consulting, LLC	100.00%	452		452	16
17	V	03 Housekeeping		Extended Care Consulting, LLC	100.00%	422		422	17
18	V	05 Utilities		Extended Care Consulting, LLC	100.00%	1,730		1,730	18
19	V	06 Maintenance		Extended Care Consulting, LLC	100.00%	2,684		2,684	19
20	V	17 Administrative		Extended Care Consulting, LLC	100.00%	1,980		1,980	20
21	V	19 Professional Fees	242,861	Extended Care Consulting, LLC	100.00%	8,566		(234,295)	21
22	V	20 Dues and Subscriptions		Extended Care Consulting, LLC	100.00%	1,695		1,695	22
23	V	21 Office and Clerical		Extended Care Consulting, LLC	100.00%	13,872		13,872	23
24	V	24 Seminar and Travel		Extended Care Consulting, LLC	100.00%	53		53	24
25	V	25 Other Staff Admin. Trans.		Extended Care Consulting, LLC	100.00%	309		309	25
26	V	26 Insurance		Extended Care Consulting, LLC	100.00%	680		680	26
27	V	30 Depreciation		Extended Care Consulting, LLC	100.00%	3,467		3,467	27
28	V	32 Interest		Extended Care Consulting, LLC	100.00%	50,964		50,964	28
29	V	33 Real Estate Taxes		Extended Care Consulting, LLC	100.00%	1,672		1,672	29
30	V	34 Rent - Building		Extended Care Consulting, LLC	100.00%	2,900		2,900	30
31	V	35 Rent - Equipment & Auto		Extended Care Consulting, LLC	100.00%	2,048		2,048	31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total		\$ 242,861			\$ 93,697	\$ *	(149,164)	39

\* 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	06 Maintenance (Pooled)		Extended Care Consulting, LLC	100.00%	6,576	\$	6,576	15
16	V	06 Maintenance (Direct)	1,192	Extended Care Consulting, LLC	100.00%	1,192			16
17	V	07 Emp. Ben. - Gen. Serv. (Pooled)		Extended Care Consulting, LLC	100.00%	1,125		1,125	17
18	V	07 Emp. Ben. - Gen. Serv. (Direct)		Extended Care Consulting, LLC	100.00%	34		34	18
19	V	17 Administrative (Pooled)		Extended Care Consulting, LLC	100.00%	7,180		7,180	19
20	V	21 Office and Clerical (Pooled)		Extended Care Consulting, LLC	100.00%	107,995		107,995	20
21	V	21 Office and Clerical (Direct)	14,906	Extended Care Consulting, LLC	100.00%	14,906			21
22	V	27 Emp. Ben. - Gen. Admin. (Pooled)		Extended Care Consulting, LLC	100.00%	18,478		18,478	22
23	V	27 Emp. Ben. - Gen. Admin. (Direct)		Extended Care Consulting, LLC	100.00%	427		427	23
24	V	22 Employee Benefits	3,220	Extended Care Consulting, LLC	100.00%			(3,220)	24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total		\$ 19,318			\$ 157,913	\$ *	138,595	39

\* 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	03 Housekeeping	\$	Extended Care Clinical, LLC	100.00%	\$ 46	\$	46	15
16	V	05 Utilities		Extended Care Clinical, LLC	100.00%	111		111	16
17	V	06 Maintenance		Extended Care Clinical, LLC	100.00%	14		14	17
18	V	19 Professional Fees	72,315	Extended Care Clinical, LLC	100.00%	963		(71,352)	18
19	V	20 Dues and Subscriptions		Extended Care Clinical, LLC	100.00%	6		6	19
20	V	21 Office & Clerical		Extended Care Clinical, LLC	100.00%	819		819	20
21	V	24 Travel and Seminar		Extended Care Clinical, LLC	100.00%	813		813	21
22	V	26 Insurance		Extended Care Clinical, LLC	100.00%	40		40	22
23	V	30 Depreciation		Extended Care Clinical, LLC	100.00%	768		768	23
24	V	32 Interest		Extended Care Clinical, LLC	100.00%	9,276		9,276	24
25	V	33 Real Estate Taxes		Extended Care Clinical, LLC	100.00%	182		182	25
26	V	01 Dietary Salary		Extended Care Clinical, LLC	100.00%	3,526		3,526	26
27	V	07 Emp. Ben. - Gen. Serv.		Extended Care Clinical, LLC	100.00%	511		511	27
28	V	10 Nursing Salary	12,535	Extended Care Clinical, LLC	100.00%	36,536		24,001	28
29	V	10a Rehab Salary		Extended Care Clinical, LLC	100.00%	1,380		1,380	29
30	V	12 Social Service Salary	11,388	Extended Care Clinical, LLC	100.00%	18,811		7,423	30
31	V	15 Emp. Ben. - Healthcare		Extended Care Clinical, LLC	100.00%	7,061		7,061	31
32	V	17 Administration Salary		Extended Care Clinical, LLC	100.00%	31,307		31,307	32
33	V	21 Office Salary		Extended Care Clinical, LLC	100.00%	6,202		6,202	33
34	V	27 Emp. Ben. - Gen. Admin.		Extended Care Clinical, LLC	100.00%	5,439		5,439	34
35	V	22 Employee Benefits	4,785	Extended Care Clinical, LLC	100.00%			(4,785)	35
36	V								36
37	V								37
38	V								38
39	Total		\$ 101,023			\$ 123,811	\$ *	22,788	39

\* 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	1 Dietary	\$ 43	Xcel Supply, LLC	100.00%	\$ 39	\$ (4) 15
16	V	3 Housekeeping	39,369	Xcel Supply, LLC	100.00%	35,754	(3,615) 16
17	V	4 Laundry	10,891	Xcel Supply, LLC	100.00%	9,891	(1,000) 17
18	V	6 Repairs & Maintenance	3,198	Xcel Supply, LLC	100.00%	2,905	(294) 18
19	V	10 Nursing	119,853	Xcel Supply, LLC	100.00%	108,847	(11,006) 19
20	V	11 Activities		Xcel Supply, LLC	100.00%		
21	V	12 Social Service		Xcel Supply, LLC	100.00%		
22	V	20 Dues, Fees And Subscriptions		Xcel Supply, LLC	100.00%		
23	V	21 Office And Clerical		Xcel Supply, LLC	100.00%		
24	V	22 Employee Benefits	4,095	Xcel Supply, LLC	100.00%	3,719	(376) 24
25	V	24 Seminars & Education		Xcel Supply, LLC	100.00%		
26	V	39 Ancillary	83,754	Xcel Supply, LLC	100.00%	76,063	(7,691) 26
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		\$ 261,203			\$ 237,216	\$ * (23,987) 39

\* 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	22 Employee Health Insurance	\$	CCS Employee Benefits Group	100.00%	\$ 158,440	\$ 158,440	15
16	V							16
17	V							17
18	V							18
19	V	22 Employee Health Insurance	158,440	CCS Employee Benefits Group	100.00%		(158,440)	19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	<b>Total</b>		\$ 158,440			\$ 158,440	\$ *	39

\* 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	06 Repairs	\$	Vent Lease, LLC.	100.00%	\$ 3,135	\$	3,135	15
16	V	19 Professional Fees		Vent Lease, LLC.	100.00%	172		172	16
17	V	21 Office and Clerical		Vent Lease, LLC.	100.00%	266		266	17
18	V	25 Auto Expense / Travel		Vent Lease, LLC.	100.00%	14		14	18
19	V	26 Insurance		Vent Lease, LLC.	100.00%	177		177	19
20	V	30 Depreciation		Vent Lease, LLC.	100.00%	8,159		8,159	20
21	V	32 Interest		Vent Lease, LLC.	100.00%	1,374		1,374	21
22	V	30 Depreciation - Matrix		Vent Lease, LLC.	100.00%	9,018		9,018	22
23	V	32 Interest - Matrix		Vent Lease, LLC.	100.00%	1,630		1,630	23
24	V	21 Office and Clerical	11,080	Vent Lease, LLC.	100.00%			(11,080)	24
25	V	39 Ancillary	31,860	Vent Lease, LLC.	100.00%			(31,860)	25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total		\$ 42,940			\$ 23,945	\$ *	(18,995)	39

\* 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	39 Therapy	\$ 818,942	TriCare Rehab		\$ 826,332	\$ 7,390	15	
16	V	10A Rehab		TriCare Rehab		26,428	26,428	16	
17	V							17	
18	V							18	
19	V							19	
20	V							20	
21	V							21	
22	V							22	
23	V							23	
24	V							24	
25	V							25	
26	V							26	
27	V							27	
28	V							28	
29	V							29	
30	V							30	
31	V							31	
32	V							32	
33	V							33	
34	V							34	
35	V							35	
36	V							36	
37	V							37	
38	V							38	
39	<b>Total</b>		\$ 818,942			\$ 852,760	\$ *	33,818	39

\* 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	01 Dietary	\$	Care Centers Health Systems, Inc.	100.00%	\$ 995	\$	995	15
16	V	03 Housekeeping		Care Centers Health Systems, Inc.	100.00%				16
17	V	05 Heat and Other Utilities		Care Centers Health Systems, Inc.	100.00%	75		75	17
18	V	06 Maintenance		Care Centers Health Systems, Inc.	100.00%	58		58	18
19	V	19 Professional Fees		Care Centers Health Systems, Inc.	100.00%	80		80	19
20	V	20 Dues, Fees, Subscriptions		Care Centers Health Systems, Inc.	100.00%	33		33	20
21	V	21 Clerical and General Office		Care Centers Health Systems, Inc.	100.00%	409		409	21
22	V	25 Other Admin. Staff Transport.		Care Centers Health Systems, Inc.	100.00%	62		62	22
23	V	26 Insurance		Care Centers Health Systems, Inc.	100.00%	153		153	23
24	V	30 Depreciation		Care Centers Health Systems, Inc.	100.00%	158		158	24
25	V	32 Interest		Care Centers Health Systems, Inc.	100.00%				25
26	V	33 Real Estate Taxes		Care Centers Health Systems, Inc.	100.00%				26
27	V	34 Rent - Building		Care Centers Health Systems, Inc.	100.00%	705		705	27
28	V	35 Rent - Equipment		Care Centers Health Systems, Inc.	100.00%	7		7	28
29	V	01 Dietary	3,464	Care Centers Health Systems, Inc.	100.00%	1,383		(2,081)	29
30	V	02 Food		Care Centers Health Systems, Inc.	100.00%				30
31	V	03 Housekeeping		Care Centers Health Systems, Inc.	100.00%				31
32	V	10 Nursing		Care Centers Health Systems, Inc.	100.00%				32
33	V	22 Employee Benefits		Care Centers Health Systems, Inc.	100.00%				33
34	V	25 Other Admin. Staff Transport.		Care Centers Health Systems, Inc.	100.00%				34
35	V	39 Ancillary	7,113	Care Centers Health Systems, Inc.	100.00%	2,839		(4,274)	35
36	V	17 Administrative		Care Centers Health Systems, Inc.	100.00%	2,160		2,160	36
37	V	21 Clerical and General Office		Care Centers Health Systems, Inc.	100.00%	2,205		2,205	37
38	V	27 Employee Benefits		Care Centers Health Systems, Inc.	100.00%	943		943	38
39	Total		\$ 10,577			\$ 12,265	\$ *	1,688	39

\* 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		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	<b>Total</b>		\$			\$	\$ *	39

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

Facility Name &amp; ID Number

Lakewood Nursing &amp; Rehab Center

# 0046169

Report Period Beginning:

01/01/09

Ending:

12/31/09

## 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	Eric Rothner	Shareholder	Administrative	1.00%	See Attached	0.90	3.00%		\$		1
2	Mark Steinberg	Relative	Administrative	0.00%	See Attached	1.65	3.00%	AI Sal/AI Fee	4,997	17-7	2
3	Adam Vales	Relative	Clerical	0.00%	See Attached	0.92	2.30%	Alloc. Salary	1,662	22-7	3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 6,659		13

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lakewood Nursing & Rehab Center

# 0046169

Report Period Beginning:

01/01/09

Ending: 12/31/09

**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 \_\_\_\_\_

Street Address \_\_\_\_\_

City / State / Zip Code \_\_\_\_\_

Phone Number ( ) \_\_\_\_\_

Fax Number ( ) \_\_\_\_\_

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					\$	\$		\$	1
2									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	<b>TOTALS</b>				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lakewood Nursing & Rehab Center

# 0046169

Report Period Beginning:

01/01/09

Ending: 12/31/09

VIII. ALLOCATION OF INDIRECT COSTS

Name of Related Organization Extended Care Consulting LLC  
 Street Address 2201 West Main Street  
 City / State / Zip Code Evanston, Illinois 60202  
 Phone Number ( 847) 905-3000  
 Fax Number ( 847) 905-3030

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.

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	01	Dietary	Patient Days	30	\$ 6,770	\$	41,289	\$ 203	1
2	02	Food	Patient Days	30	15,058		41,289	452	2
3	03	Housekeeping	Patient Days	30	14,059		41,289	422	3
4	05	Utilities	Patient Days	30	57,646		41,289	1,730	4
5	06	Maintenance	Patient Days	30	89,465		41,289	2,684	5
6	17	Administrative	Patient Days	30	66,000		41,289	1,980	6
7	19	Professional Fees	Patient Days	30	285,482		41,289	8,566	7
8	20	Dues and Subscriptions	Patient Days	30	56,488		41,289	1,695	8
9	21	Office and Clerical	Patient Days	30	462,313		41,289	13,872	9
10	24	Seminar and Travel	Patient Days	30	1,768		41,289	53	10
11	25	Other Staff Admin. Trans.	Patient Days	30	10,309		41,289	309	11
12	26	Insurance	Patient Days	30	22,668		41,289	680	12
13	30	Depreciation	Patient Days	30	115,549		41,289	3,467	13
14	32	Interest	Patient Days	30	1,698,489		41,289	50,964	14
15	33	Real Estate Taxes	Patient Days	30	55,709		41,289	1,672	15
16	34	Rent - Building	Patient Days	30	96,636		41,289	2,900	16
17	35	Rent - Equipment & Auto	Patient Days	30	68,244		41,289	2,048	17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 3,122,653	\$		\$ 93,697	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lakewood Nursing & Rehab Center

# 0046169

Report Period Beginning:

01/01/09

Ending: 12/31/09

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 Extended Care Consulting LLC  
 Street Address 2201 West Main Street  
 City / State / Zip Code Evanston, Illinois 60202  
 Phone Number ( 847) 905-3000  
 Fax Number ( 847) 905-3030

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	06	Maintenance (Pooled)	Patient Days	1,376,056	30	219,177	219,177	41,289	6,576	1
2	06	Maintenance (Direct)	Direct		30	82,905	82,905		1,192	2
3	07	Emp. Ben. - Gen. Serv. (Pooled)	Patient Days	1,376,056	30	37,501		41,289	1,125	3
4	07	Emp. Ben. - Gen. Serv. (Direct)	Direct		30	8,464	8,464		34	4
5	17	Administrative (Pooled)	Patient Days	1,376,056	30	239,303	239,303	41,289	7,180	5
6	21	Office and Clerical (Pooled)	Patient Days	1,376,056	30	3,599,211	3,599,211	41,289	107,995	6
7	21	Office and Clerical (Direct)	Direct		30	654,174			14,906	7
8	27	Emp. Ben. - Gen. Admin. (Pooled)	Patient Days	1,376,056	30	615,819	615,819	41,289	18,478	8
9	27	Emp. Ben. - Gen. Admin. (Direct)	Direct		30	73,650	73,650	41,289	427	9
10	22	Employee Benefits								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					\$ 5,530,203	\$ 4,838,529		\$ 157,913	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lakewood Nursing & Rehab Center

# 0046169

Report Period Beginning:

01/01/09

Ending: 12/31/09

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

Extended Care Clinical LLC

Street Address

2201 West Main Street

City / State / Zip Code

Evanston, Illinois 60202

Phone Number

( 847) 905-3000

Fax Number

( 847) 905-3030

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	03	Housekeeping	Patient Days	30	\$ 1,549	\$	41,289	\$ 46	1
2	05	Utilities	Patient Days	30	3,693		41,289	111	2
3	06	Maintenance	Patient Days	30	477		41,289	14	3
4	19	Professional Fees	Patient Days	30	32,105		41,289	963	4
5	20	Dues and Subscriptions	Patient Days	30	213		41,289	6	5
6	21	Office & Clerical	Patient Days	30	27,296		41,289	819	6
7	24	Travel and Seminar	Patient Days	30	27,079		41,289	813	7
8	26	Insurance	Patient Days	30	1,342		41,289	40	8
9	30	Depreciation	Patient Days	30	25,586		41,289	768	9
10	32	Interest	Patient Days	30	309,136		41,289	9,276	10
11	33	Real Estate Taxes	Patient Days	30	6,053		41,289	182	11
12	01	Dietary Salary	Patient Days	30	117,506	117,506	41,289	3,526	12
13	07	Emp. Ben. - Gen. Serv.	Patient Days	30	17,040		41,289	511	13
14	10	Nursing Salary	Patient Days	30	799,889	799,889	41,289	24,001	14
15	10a	Rehab Salary	Patient Days	30	45,993	45,993	41,289	1,380	15
16	12	Social Service Salary	Patient Days	30	247,396	247,396	41,289	7,423	16
17	15	Emp. Ben. - Healthcare	Patient Days	30	158,537		41,289	4,757	17
18	17	Administration Salary	Patient Days	30	1,043,375	1,043,375	41,289	31,307	18
19	21	Office Salary	Patient Days	30	206,680	206,680	41,289	6,202	19
20	27	Emp. Ben. - Gen. Admin.	Patient Days	30	181,271		41,289	5,439	20
21	10	Nursing Salary	Direct Allocation		494,488	494,488	41,289	12,535	21
22	12	Social Service Salary	Direct Allocation		196,033	196,033		11,388	22
23	15	Emp. Ben. - Healthcare	Direct Allocation		82,560			2,304	23
24									24
25	TOTALS				\$ 4,025,296	\$ 3,151,360		\$ 123,811	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lakewood Nursing & Rehab Center

# 0046169

Report Period Beginning:

01/01/09

Ending: 12/31/09

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 Xcel Supply, LLC  
 Street Address 2201 Main Street  
 City / State / Zip Code Evanston, IL 60202  
 Phone Number ( 847)328-7600  
 Fax Number ( 847)328-7615

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	1	Dietary	Direct Allocation		\$	\$		\$ 39	1
2	3	Housekeeping	Direct Allocation					35,754	2
3	4	Laundry	Direct Allocation					9,891	3
4	6	Repairs & Maintenance	Direct Allocation					2,905	4
5	10	Nursing	Direct Allocation					108,847	5
6	11	Activities	Direct Allocation						6
7	12	Social Service	Direct Allocation						7
8	20	Dues, Fees And Subscriptions	Direct Allocation						8
9	21	Office And Clerical	Direct Allocation						9
10	22	Employee Benefits	Direct Allocation					3,719	10
11	24	Seminars & Education	Direct Allocation						11
12	39	Ancillary	Direct Allocation					76,063	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				\$	\$		\$ 237,216	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lakewood Nursing & Rehab Center

# 0046169

Report Period Beginning:

01/01/09

Ending: 12/31/09

VIII. ALLOCATION OF INDIRECT COSTS

Name of Related Organization CCS Employee Benefits Group, Inc.  
 Street Address 2201 Main Street  
 City / State / Zip Code Evanston, Illinois 60202  
 Phone Number ( 847)905-4000  
 Fax Number ( 847)905-4040

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.

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	22	Employee Health Insurance	Direct Allocation		\$	\$		\$ 158,440	1
2									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	TOTALS				\$	\$		\$ 158,440	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lakewood Nursing & Rehab Center

# 0046169

Report Period Beginning:

01/01/09

Ending: 12/31/09

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 Vent Lease, LLC  
 Street Address 2201 W. Main Street  
 City / State / Zip Code Evanston, Illinois 60202  
 Phone Number ( 847) 674-1180  
 Fax Number ( 847) 673-7741

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	06	Repairs	Direct Billing	821,185	26	\$ 80,807	\$ 31,860	\$ 3,135	1
2	19	Professional Fees	Direct Billing	821,185	26	4,427	31,860	172	2
3	21	Office and Clerical	Direct Billing	821,185	26	6,852	31,860	266	3
4	25	Auto Expense / Travel	Direct Billing	821,185	26	356	31,860	14	4
5	26	Insurance	Direct Billing	821,185	26	4,573	31,860	177	5
6	30	Depreciation	Direct Billing	821,185	26	218,810	31,860	8,159	6
7	32	Interest	Direct Billing	821,185	26	35,420	31,860	1,374	7
8	30	Depreciation - Matrix	Patient Days	1,376,056	30	300,546	41,289	9,018	8
9	32	Interest - Matrix	Patient Days	1,376,056	30	54,323	41,289	1,630	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					\$ 706,114	\$	\$ 23,945	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lakewood Nursing & Rehab Center

# 0046169

Report Period Beginning:

01/01/09

Ending: 12/31/09

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 TriCare Rehab  
 Street Address 150 Fencil Lane  
 City / State / Zip Code Hillside, IL 60162  
 Phone Number ( 773) 449-9400  
 Fax Number ( 773) 449-9700

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	39	Therapy	Direct Allocation		\$	\$		\$ 826,332	1
2	10A	Rehab	Direct Allocation					26,428	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	TOTALS				\$	\$		\$ 852,760	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lakewood Nursing & Rehab Center

# 0046169

Report Period Beginning:

01/01/09

Ending: 12/31/09

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 Care Centers Health Systems, Inc.  
 Street Address 200 Howard  
 City / State / Zip Code Des Plaines, Illinois 60018  
 Phone Number ( 224) 612-5662  
 Fax Number ( 224) 612-5862

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	01	Dietary	Gross Billable Income	3,421,940	26	72,652	46,842	995	1	
2	03	Housekeeping	Gross Billable Income	3,421,940	26		46,842		2	
3	05	Heat and Other Utilities	Gross Billable Income	3,421,940	26	5,507	46,842	75	3	
4	06	Maintenance	Gross Billable Income	3,421,940	26	4,211	46,842	58	4	
5	19	Professional Fees	Gross Billable Income	3,421,940	26	5,880	46,842	80	5	
6	20	Dues, Fees, Subscriptions	Gross Billable Income	3,421,940	26	2,401	46,842	33	6	
7	21	Clerical and General Office	Gross Billable Income	3,421,940	26	29,869	46,842	409	7	
8	25	Other Admin. Staff Transport.	Gross Billable Income	3,421,940	26	4,509	46,842	62	8	
9	26	Insurance	Gross Billable Income	3,421,940	26	11,210	46,842	153	9	
10	30	Depreciation	Gross Billable Income	3,421,940	26	11,528	46,842	158	10	
11	32	Interest	Gross Billable Income	3,421,940	26		46,842		11	
12	33	Real Estate Taxes	Gross Billable Income	3,421,940	26		46,842		12	
13	34	Rent - Building	Gross Billable Income	3,421,940	26	51,522	46,842	705	13	
14	35	Rent - Equipment	Gross Billable Income	3,421,940	26	547	46,842	7	14	
15	01	Dietary	Direct Billable Income	206,522	26	82,445	3,464	1,383	15	
16	02	Food	Direct Billable Income	2,784	26	1,111			16	
17	03	Housekeeping	Direct Billable Income		26				17	
18	10	Nursing	Direct Billable Income	5,466	26	2,182			18	
19	22	Employee Benefits	Direct Billable Income	411	26	164			19	
20	25	Other Admin. Staff Transport.	Direct Billable Income		26				20	
21	39	Ancillary	Direct Billable Income	3,206,757	26	1,280,152	7,113	2,839	21	
22	17	Administrative	Gross Billable Income	3,421,940	26	157,769	157,769	46,842	2,160	22
23	21	Clerical and General Office	Gross Billable Income	3,421,940	26	161,081	161,081	46,842	2,205	23
24	27	Employee Benefits	Gross Billable Income	3,421,940	26	68,860	46,842	943	24	
25	TOTALS					\$ 1,953,599	\$ 318,850	\$ 12,265	25	

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lakewood Nursing & Rehab Center

# 0046169

Report Period Beginning:

01/01/09

Ending: 12/31/09

**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 \_\_\_\_\_

Street Address \_\_\_\_\_

City / State / Zip Code \_\_\_\_\_

Phone Number ( ) \_\_\_\_\_

Fax Number ( ) \_\_\_\_\_

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					\$	\$		\$	1
2									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	<b>TOTALS</b>				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name &amp; ID Number

Lakewood Nursing &amp; Rehab Center

# 0046169

Report Period Beginning:

01/01/09

Ending:

12/31/09

## 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
	<b>A. Directly Facility Related</b>																			
	<b>Long-Term</b>																			
1	Business Partners		X	Mortgage			\$	\$ 4,777,626			\$ 308,479	1								
2	Rothner Health GII		X					662,801			21,540	2								
3	Hunter Management		X								37,596	3								
4												4								
5	See Supplemental Schedule											5								
	<b>Working Capital</b>																			
6	Ridgeland		X	Construction Loan				711,908			52,508	6								
7	Eric Rothner (Private Bank)		X					135,550			5,342	7								
8	See Supplemental Schedule										63,244	8								
9	TOTAL Facility Related						\$	\$ 6,287,885			\$ 488,709	9								
	<b>B. Non-Facility Related*</b>																			
10	Interest Income		X								(93,937)	10								
11	Interest Income (Bldg Co.)		X								(57,339)	11								
12												12								
13	See Supplemental Schedule											13								
14	TOTAL Non-Facility Related						\$	\$			\$ (151,276)	14								
15	TOTALS (line 9+line14)						\$	\$ 6,287,885			\$ 337,433	15								

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V.      \$ None                      Line # N/A

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name &amp; ID Number

Lakewood Nursing &amp; Rehab Center

# 0046169

Report Period Beginning:

01/01/09

Ending:

12/31/09

## IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE - SUPPLEMENTAL SCHEDULE

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

	1	2	3	4	5	6		7	8	9	10									
						Name of Lender	Related**					Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
							YES								NO	Original				Balance
	<b>A. Directly Facility Related</b>																			
	<b>Long-Term</b>																			
1							\$	\$			\$	1								
2												2								
3												3								
4												4								
5												5								
6												6								
7	<b>TOTAL Long-Term</b>																			
	<b>Working Capital</b>																			
8	Alloc. From EC Consulting		X				\$	\$			\$	50,964	8							
9	Alloc. From EC Clinical		X									9,276	9							
10	Alloc. From Vent Lease		X									3,004	10							
11													11							
12													12							
13													13							
14	<b>TOTAL Working Capital</b>																			
	<b>B. Non-Facility Related*</b>																			
15							\$	\$			\$		15							
16													16							
17													17							
18													18							
19													19							
20	<b>TOTAL Non-Facility Related</b>																			

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

(See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

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

(See instructions.)





**IMPORTANT NOTICE**

**TO:** Long Term Care Facilities with Real Estate Tax Rates **RE:** 2008 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2008 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2008.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2008 real estate tax bill to Healthcare and Family Services, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

**Please send these items in with your completed 2009 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed.** If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

**2008 LONG TERM CARE REAL ESTATE TAX STATEMENT**

FACILITY NAME Lakewood Nursing & Rehab Center COUNTY Will

FACILITY IDPH LICENSE NUMBER 0046169

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE (847) 236-1111 FAX #: (847) 236-1155

**A. Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

	(A)	(B)	(C)	(D)
	<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1.	_____	_____	\$ _____	\$ _____
2.	_____	_____	\$ _____	\$ _____
3.	_____	_____	\$ _____	\$ _____
4.	_____	_____	\$ _____	\$ _____
5.	_____	_____	\$ _____	\$ _____
6.	_____	_____	\$ _____	\$ _____
7.	_____	_____	\$ _____	\$ _____
8.	_____	_____	\$ _____	\$ _____
9.	_____	_____	\$ _____	\$ _____
10.	_____	_____	\$ _____	\$ _____
<b>TOTALS</b>			\$ _____	\$ _____

**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        NO

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

**C. Tax Bills**

Attach a copy of the original 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.

Facility Name & ID Number Lakewood Nursing & Rehab Center

# 0046169

Report Period Beginning:

01/01/09

Ending:

12/31/09

**X. BUILDING AND GENERAL INFORMATION:**

A. Square Feet: 15,925 B. General Construction Type: Exterior Brick Frame Steel Number of Stories 1

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:**

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>Facility</u>	<u>273,121</u>	<u>2003</u>	<u>\$ 237,379</u>	<u>1</u>
2	<u>Allocated From ECC 2201 Main LLC /EC Clinical 2201 Main</u>			<u>11,012</u>	<u>2</u>
3	<b>TOTALS</b>	<b>273,121</b>		<b>\$ 248,391</b>	<b>3</b>

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lakewood Nursing & Rehab Center

# 0046169

Report Period Beginning:

01/01/09

Ending:

12/31/09

**XI. OWNERSHIP COSTS (continued)**

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	<b>Improvement Type**</b>										
9	Various		2003		11,804		20	1,095	1,095	7,064	9
10	Various		2004		41,672		20	2,331	2,331	12,619	10
11	Various		2005		14,592		20	1,287	1,287	5,582	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

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

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

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67	Related Building Company (Pages 12F & 12G)	8,431,887	223,384		365,718	142,334	1,633,297	67
68	Related Party Allocations (Pages 12H & 12I)	43,571	2,976		2,976		18,127	68
69	Financial Statement Depreciation		45,178			(45,178)		69
70	TOTAL (lines 4 thru 69)	\$ 8,543,526	\$ 271,538		\$ 373,407	\$ 101,869	\$ 1,676,689	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name &amp; ID Number Lakewood Nursing &amp; Rehab Center

# 0046169

Report Period Beginning:

01/01/09

Ending:

12/31/09

## 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	<b>Totals from Page 12A, Carried Forward</b>		\$ 8,543,526	\$ 271,538		\$ 373,407	\$ 101,869	\$ 1,676,689	1
2	Preferred Mechanical - Update Lobby/Office Ac System	2006	7,200		20	600	600	2,100	2
3	Noble Blacktop Serv. - Work On Parking Lot & Ramp	2006	8,825		20	883	883	3,015	3
4	Rf Technologies - Code Alert/Model 70	2006	10,393		20	2,079	2,079	6,755	4
5	Alarm System	2006	8,817		20	1,260	1,260	4,303	5
6	Hth Telecommunications - New Phone & Lines In New Wing	2006	27,279		20	2,728	2,728	10,002	6
7	R&R Septic & Sewer Svc 06-5404	2006	3,750		20	750	750	2,313	7
8	2900 2" Uniduct Latching Raceway	2007	6,013		20	301	301	902	8
9	Blinds For 3 Rooms	2007	2,746		20	275	275	778	9
10	Windows	2007	6,000		20	1,200	1,200	3,200	10
11	Painting (Transfer Expense From Home Office)	2007	9,174		20			9,174	11
12	Install 1 New Twin 100A Switch	2007	3,500		20	175	175	379	12
13	5 X \$1986.88 Gazebo	2007	9,934		20	497	497	1,283	13
14	Healthcare Security System	2007	3,182		20	159	159	464	14
15	Remove Wallpaper From Walls	2008	2,500		20			2,500	15
16	Alarm System	2008	5,643		20	282	282	564	16
17	Plaster & Paint 15 Rooms	2008	7,567		20	631	631	7,567	17
18	Painting (Transfer From Home Office)	2008	9,256		20	1,543	1,543	9,256	18
19	Painting (Transfer From Home Office)	2008	10,036		20	2,509	2,509	10,036	19
20	New Laundry Room	2008	3,025		20	151	151	227	20
21	Repairs Of Ice Cream Parlor	2008	4,380		20	219	219	292	21
22	Painting (Reclass From Home Office)	2008	4,481		20	3,361	3,361	4,481	22
23	Painting (Reclass From Home Office)	2008	896		20	672	672	896	23
24	Repair Water Line	2008	5,832		20	292	292	365	24
25	Painting (Transfer Expense From Home Office)	2008	6,025		20	5,021	5,021	6,025	25
26	Painting (Transfer Expense From Home Office)	2008	1,205		20	1,004	1,004	1,205	26
27	Install Expansion Joint	2008	4,500		20	225	225	263	27
28	Roof Repair	2009	2,650		20	88	88	88	28
29	Painting	2009	7,624		20	2,541	2,541	2,541	29
30	Painting	2009	6,744		20	1,686	1,686	1,686	30
31	Painting	2009	4,216		20	2,108	2,108	2,108	31
32	Painting	2009	4,995		20	2,081	2,081	2,081	32
33	Ceiling	2009	5,250		20	44	44	44	33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 8,747,164	\$ 271,538		\$ 408,772	\$ 137,234	\$ 1,773,582	34

SEE ACCOUNTANTS' COMPILATION REPORT

\*\*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	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	<b>Totals from Page 12B, Carried Forward</b>		\$ 8,747,164	\$ 271,538		\$ 408,772	\$ 137,234	\$ 1,773,582	1
2	Ceiling	2009	6,833		20	28	28	28	2
3	Painting	2009	3,493		20	275	275	275	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	<b>TOTAL (lines 1 thru 33)</b>		\$ 8,757,490	\$ 271,538		\$ 409,075	\$ 137,537	\$ 1,773,885	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Lakewood Nursing & Rehab Center

# 0046169

Report Period Beginning:

01/01/09

Ending:

12/31/09

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 8,757,490	\$ 271,538		\$ 409,075	\$ 137,537	\$ 1,773,885	1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34	TOTAL (lines 1 thru 33)	\$ 8,757,490	\$ 271,538		\$ 409,075	\$ 137,537	\$ 1,773,885	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Lakewood Nursing & Rehab Center

# 0046169

Report Period Beginning:

01/01/09

Ending:

12/31/09

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 8,757,490	\$ 271,538		\$ 409,075	\$ 137,537	\$ 1,773,885	1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34	TOTAL (lines 1 thru 33)	\$ 8,757,490	\$ 271,538		\$ 409,075	\$ 137,537	\$ 1,773,885	34

SEE ACCOUNTANTS' COMPILATION REPORT

\*\*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	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	<b>Building Company Information</b>								1
2	<b>Buildings:</b>								2
3	<b>131 Beds</b>	1971	2,099,630		39	49,105	49,105	343,741	3
4									4
5									5
6									6
7									7
8	<b>Leasehold Improvements:</b>								8
9	<b>Construction Project</b>	2005	1,354,202		20	67,710	67,710	341,374	9
10	<b>Construction Project</b>	2006	4,978,055		20	248,903	248,903	948,182	10
11									11
12	<b>Depreciation</b>			223,384			(223,384)		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

SEE ACCOUNTANTS' COMPILATION REPORT

\*\*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	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	<b>Building Company Information Continued</b>		\$	\$		\$	\$	\$	1
2									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	<b>TOTAL (12F &amp; 12G lines 1 thru 33)</b>		\$ 8,431,887	\$ 223,384		\$ 365,718	\$ 142,334	\$ 1,633,297	34

SEE ACCOUNTANTS' COMPILATION REPORT

\*\*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	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	<b>Related Party Information</b>		\$	\$		\$	\$	\$	1
2	<b>Buildings:</b>								2
3	Allocated From ECC 2201 Main LLC	2002	13,669	350	39	350		2,556	3
4	Allocated From EC Clinical 2201 Main LLC	2002	1,506	39	39	39		282	4
5									5
6									6
7									7
8	<b>Leasehold Improvements:</b>								8
9	Allocated From Extended Care Consulting	2007	138	2	20	2		16	9
10	Allocated From Extended Care Consulting	2009	83	4	20	4		4	10
11									11
12	Allocated From ECC 2201 Main LLC	2002	11,292	1,032	20	1,032		6,202	12
13	Allocated From ECC 2201 Main LLC	2003	13,307	1,216	20	1,216		7,308	13
14	Allocated From ECC 2201 Main LLC	2005	661	70	20	70		238	14
15	Allocated From ECC 2201 Main LLC	2009	119	6	20	6		6	15
16									16
17	Allocated From EC Clinical 2201 Main LLC	2002	1,244	114	20	114		683	17
18	Allocated From EC Clinical 2201 Main LLC	2003	1,466	134	20	134		805	18
19	Allocated From EC Clinical 2201 Main LLC	2005	73	8	20	8		26	19
20	Allocated From EC Clinical 2201 Main LLC	2009	13	1	20	1		1	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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Lakewood Nursing & Rehab Center

# 0046169

Report Period Beginning:

01/01/09

Ending:

12/31/09

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
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								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 (12H & 12I lines 1 thru 33)	\$ 43,571	\$ 2,976		\$ 2,976	\$	\$ 18,127	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Lakewood Nursing & Rehab Center

# 0046169

Report Period Beginning:

01/01/09

Ending:

12/31/09

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	\$ 498,872	\$ 83,640	\$ 78,535	\$ (5,105)	10	\$ 313,023	71
72	Current Year Purchases	54,282	6,958	7,997	1,039	10	7,997	72
73	Fully Depreciated Assets	111,625				10	111,625	73
74								74
75	TOTALS	\$ 664,779	\$ 90,598	\$ 86,532	\$ (4,066)		\$ 432,645	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		Alloc. From ECC	2009	\$ 9,649	\$ 151	\$ 151	\$	5	\$ 9,196	76
77		Alloc. From EC Clinical	2009	2,157	431	431		5	1,270	77
78		Alloc From EC Health Syst.	2009	401	80	80		5	121	78
79										79
80	TOTALS			\$ 12,207	\$ 662	\$ 662	\$		\$ 10,587	80

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 9,682,867	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 362,798	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 496,269	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 133,471	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 2,217,117	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

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

If NO, see instructions.  YES  NO

	1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:	<u>Storage Unit Rental</u>		\$ <u>832</u>			3
4	Additions						4
5	<u>Allocated From Extended Care Health Systems</u>			<u>705</u>			5
6	<u>Allocated From Extended Care Consulting</u>			<u>2,900</u>			6
7	TOTAL			\$ <u>4,437</u>			7

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized by the length of the lease \_\_\_\_\_.

9. Option to Buy:  YES  NO Terms: \_\_\_\_\_\*

**B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)**

15. Is Movable equipment rental included in building rental?

YES  NO

16. Rental Amount for movable equipment: \$ 7,338 Description: See Attached Schedule

(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. \_\_\_\_\_/2009 \$ \_\_\_\_\_

13. \_\_\_\_\_/2010 \$ \_\_\_\_\_

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

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

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

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

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

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>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		Contract	Total
		1	2		
		Drop-outs	Completed		
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	<b>TOTALS</b>	\$	\$	\$	\$
10	<b>SUM OF line 9, col. 1 and 2 (e)</b>	\$			

**C. CONTRACTUAL INCOME**

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

\$

**D. NUMBER OF CNAs TRAINED**

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

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

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

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

	Service	1 Schedule V Line & Column Reference	2		3		4		5	6	7	8		
			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 - 03	hrs	\$		\$	334,331	\$			\$	334,331	1	
2	Licensed Speech and Language Development Therapist	39 - 03	hrs				98,555					98,555	2	
3	Licensed Recreational Therapist		hrs										3	
4	Licensed Physical Therapist	39 - 03	hrs				472,981					472,981	4	
5	Physician Care		visits										5	
6	Dental Care		visits										6	
7	Work Related Program		hrs										7	
8	Habilitation		hrs										8	
9	Pharmacy	39 - 02	# of prescrpts						552,686			552,686	9	
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs										10	
11	Academic Education		hrs										11	
12	Other (specify):												12	
13	Other (specify): <u>See Supplemental</u>						80,444		213,910			294,354	13	
14	TOTAL			\$		\$	986,311	\$	766,596		\$	1,752,907	14	

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lakewood Nursing & Rehab Center# 0046169Report Period Beginning: 01/01/09

Ending:

12/31/09

## XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/09

(last day of reporting year)

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

		1 Operating	2 After Consolidation*	
<b>A. Current Assets</b>				
1	Cash on Hand and in Banks	\$ 625	\$ 99,102	1
2	Cash-Patient Deposits	33,249	33,249	2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance )	461,116	461,116	3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	114,293	114,293	6
7	Other Prepaid Expenses	997	997	7
8	Accounts Receivable (owners or related parties)	801,814	(1,449,571)	8
9	Other(specify): <u>See Attached Schedule</u>	1,623,693	1,623,693	9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 3,035,787	\$ 882,879	10
<b>B. Long-Term Assets</b>				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		237,379	13
14	Buildings, at Historical Cost		4,084,382	14
15	Leasehold Improvements, at Historical Cost	205,220	5,230,325	15
16	Equipment, at Historical Cost	510,775	510,775	16
17	Accumulated Depreciation (book methods)	(391,791)	(2,029,969)	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): <u>See Attached Schedule</u>		31,616	23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 324,204	\$ 8,064,508	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 3,359,991	\$ 8,947,387	25

		1 Operating	2 After Consolidation*	
<b>C. Current Liabilities</b>				
26	Accounts Payable	\$ 713,202	\$ 713,203	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	23,371	23,371	28
29	Short-Term Notes Payable		1,510,259	29
30	Accrued Salaries Payable	131,543	131,543	30
31	Accrued Taxes Payable (excluding real estate taxes)	4,313	4,313	31
32	Accrued Real Estate Taxes(Sch.IX-B)	80,695	80,695	32
33	Accrued Interest Payable		453,371	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
<b>Other Current Liabilities(specify):</b>				
36	<u>See Attached Schedule</u>	150,000	150,000	36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 1,103,124	\$ 3,066,755	38
<b>D. Long-Term Liabilities</b>				
39	Long-Term Notes Payable			39
40	Mortgage Payable		4,777,626	40
41	Bonds Payable			41
42	Deferred Compensation			42
<b>Other Long-Term Liabilities(specify):</b>				
43	<u>See Attached Schedule</u>			43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$	\$ 4,777,626	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 1,103,124	\$ 7,844,381	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 2,256,867	\$ 1,103,006	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 3,359,991	\$ 8,947,387	48

SEE ACCOUNTANTS' COMPILATION REPORT

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1</b> <b>Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>1,851,951</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>	<b>Pension Expense Adjustment</b>	<b>1,917</b>	<b>3</b>
<b>4</b>	<b>Due to Prior Owner Adjustment</b>	<b>309,307</b>	<b>4</b>
<b>5</b>	<b>Rounding</b>	<b>(2)</b>	<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>2,163,173</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>344,349</b>	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	<b>(250,655)</b>	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ <b>93,694</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>2,256,867</b>	<b>24</b> *

\* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name &amp; ID Number Lakewood Nursing &amp; Rehab Center

# 0046169

Report Period Beginning: 01/01/09

Ending: 12/31/09

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

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

		1	
Revenue		Amount	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 9,287,945	1
2	Discounts and Allowances for all Levels	(3,867,316)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 5,420,629	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	3,215,029	6
7	Oxygen	676	7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 3,215,705	8
<b>C. Other Operating Revenue</b>			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	1,856	13
14	Non-Patient Meals	1,422	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	551,566	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	63,136	19
20	Radiology and X-Ray	27,390	20
21	Other Medical Services	203,879	21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 849,249	23
<b>D. Non-Operating Revenue</b>			
24	Contributions	68	24
25	Interest and Other Investment Income***	93,937	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 94,005	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<u>See Supplemental Schedule</u>	237	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 237	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 9,579,825	30

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	1,326,109	31
32	Health Care	3,569,814	32
33	General Administration	1,781,866	33
<b>B. Capital Expense</b>			
34	Ownership	732,886	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	1,753,078	35
36	Provider Participation Fee	71,723	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 9,235,476	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	344,349	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 344,349	43

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

\*\* Does this agree with taxable income (loss) per Federal Income Tax Return? Not Complete 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. SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number **Lakewood Nursing & Rehab Center**

# **0046169**

Report Period Beginning:

**01/01/09**

Ending:

**12/31/09**

**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	1,642	1,880	\$ 82,514	\$ 43.89	1
2	Assistant Director of Nursing	1,764	2,023	70,195	34.70	2
3	Registered Nurses	25,612	28,476	846,508	29.73	3
4	Licensed Practical Nurses	22,660	25,048	629,187	25.12	4
5	CNAs & Orderlies	81,077	89,892	1,066,641	11.87	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	10,931	12,346	223,739	18.12	8
9	Activity Director	1,894	2,188	32,186	14.71	9
10	Activity Assistants	7,754	8,365	89,272	10.67	10
11	Social Service Workers	7,538	8,295	166,007	20.01	11
12	Dietician					12
13	Food Service Supervisor	1,878	2,163	38,968	18.02	13
14	Head Cook					14
15	Cook Helpers/Assistants	5,872	6,335	87,556	13.82	15
16	Dishwashers	16,007	17,596	154,819	8.80	16
17	Maintenance Workers	6,641	7,349	129,364	17.60	17
18	Housekeepers	16,688	18,351	176,438	9.61	18
19	Laundry	4,781	5,098	44,286	8.69	19
20	Administrator	2,109	2,193	90,878	41.44	20
21	Assistant Administrator	1,974	2,032	55,829	27.48	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	8,239	9,359	139,232	14.88	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,992	3,398	57,588	16.95	31
32	Other Health Care(specify)					32
33	Other(specify) <u>See Supplemental</u>					33
34	TOTAL (lines 1 - 33)	228,053	252,388	\$ 4,181,207 *	\$ 16.57	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	211	\$ 13,368	01-03	35
36	Medical Director	Monthly	10,800	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	1,395	10-03	39
40	Physical Therapy Consultant				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	<u>See Attached</u>		23,924		48
49	TOTAL (lines 35 - 48)	211	\$ 49,487		49

**C. CONTRACT NURSES**

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	8	\$ 190	10-03	50
51	Licensed Practical Nurses	1,794	68,555	10-03	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	1,802	\$ 68,745		53

SEE ACCOUNTANTS' COMPILATION REPORT

**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		
Patricia Long (1/1/09-12/22/09)	Administrator	0.00%	\$ 83,857	Workers' Compensation Insurance	\$ 159,068	IDPH License Fee	\$ 995		
Jeffrey Baker (12/8/09-12/31/09)	Administrator	0.00%	7,022	Unemployment Compensation Insurance	34,079	Advertising: Employee Recruitment	5,878		
Shannon Deckinga	Asst. Admin	0.00%	55,828	FICA Taxes	314,109	Health Care Worker Background Check	3,426		
				Employee Health Insurance	99,151	(Indicate # of checks performed <u>153</u> )			
				Employee Meals		Patient Background Checks	<u>200</u> 2,000		
				Illinois Municipal Retirement Fund (IMRF)*		Licenses, Inspections & Permits	801		
				Holiday Expenses	1,545	Dues & Subscriptions	2,609		
				Employee Physicals	12,050	Advertising & Promotions	18,468		
				Other Employee Welfare	16,353	Allocated From Extended Care Consult.	1,695		
						See Supplemental Schedule	39		
						Less: Public Relations Expense	( )		
						Non-allowable advertising	(18,468)		
						Yellow page advertising	( )		
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 146,707	TOTAL (agree to Schedule V, line 22, col.8)	\$ 636,355	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 17,443		
<b>B. Administrative - Other</b>				<b>E. Schedule of Non-Cash Compensation Paid to Owners or Employees</b>			<b>G. Schedule of Travel and Seminar**</b>		
Description			Amount	Description	Line #	Amount	Description	Amount	
			\$			\$	Out-of-State Travel	\$	
							In-State Travel		
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$	TOTAL		\$	Seminar Expense	6,492	
<b>C. Professional Services</b>							Allocated From Extended Care Consult.		53
Vendor/Payee	Type		Amount				Allocated From Extend. Care Clinical		813
Paycor	Payroll Services		\$ 11,126				Entertainment Expense		( )
ADP	Payroll Services		1,075				(agree to Sch. V, line 24, col. 8)		
E- Health Data Solutions	Data Processing		3,180				TOTAL	\$ 7,358	
Pinnacle Consulting	Customer Satisfaction		714						
Frost, Ruttenberg & Rothblatt	Accounting		20,266						
See Attached	Legal		2,708						
Personnel Planners	Unemployment Consult.		2,540						
Fomark	Resident Chart Review		203						
Chad Cournaya	Medicare Consultant		206						
Legal Architects	Architecture		1,518						
Allegiance	Employee Compliance		56						
See Supplemental Schedule			322,324						
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 365,916						

\* Attach copy of IMRF notifications  
SEE ACCOUNTANTS' COMPILATION REPORT

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

**SEE ACCOUNTANTS' COMPILATION REPORT**

Facility Name &amp; ID Number Lakewood Nursing &amp; Rehab Center

# 0046169

Report Period Beginning: 01/01/09

Ending: 12/31/09

**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (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? 10 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 56,269 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. \$ 71,723  
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. \$ Yes Has any meal income been offset against related costs? Yes Indicate the amount. \$ 1,422
- (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? N/A 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? 100% Ln 14
- 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? N/A  
Attach invoices and a summary of services for all architect and appraisal fees.