

Facility Name & ID Number Parkview Terrace

0045294 Report Period Beginning: 1/1/09 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	72	Skilled (SNF)	72	26,280	1
2		Skilled Pediatric (SNF/PED)			2
3	48	Intermediate (ICF)	48	17,520	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	120	TOTALS	120	43,800	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	147	26	1,114	1,287	8
9	SNF/PED					9
10	ICF	22,067	1,255	1,407	24,729	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	22,214	1,281	2,521	26,016	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 59.40%

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

None (Do not include bed-hold days in Section B.)

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

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

None

F. Does the facility maintain a daily midnight census?

Yes

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

YES NO Note: Non-allowable costs have been eliminated in Schedule V, Column 7.

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

YES NO

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

Date started 1/1/01

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

YES Date 1/1/01 NO

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

YES NO If YES, enter number of beds certified 22 and days of care provided 906

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.

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1/1/09

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
	A. General Services										
1	Dietary	134,487	15,894	3,070	153,451		153,451		153,451		1
2	Food Purchase		141,669		141,669		141,669		141,669		2
3	Housekeeping	108,922	19,429		128,351		128,351		128,351		3
4	Laundry	48,775	12,722		61,497		61,497		61,497		4
5	Heat and Other Utilities			111,756	111,756		111,756	577	112,333		5
6	Maintenance	85,258	2,254	19,985	107,497		107,497		107,497		6
7	Other (specify):*										7
8	TOTAL General Services	377,442	191,968	134,811	704,221		704,221	577	704,798		8
	B. Health Care and Programs										
9	Medical Director			18,000	18,000		18,000		18,000		9
10	Nursing and Medical Records	1,143,742	63,945	614	1,208,301		1,208,301	78,441	1,286,742		10
10a	Therapy	58,547		208,515	267,062		267,062		267,062		10a
11	Activities	58,576	871	549	59,996		59,996		59,996		11
12	Social Services	41,505		549	42,054		42,054		42,054		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,302,370	64,816	228,227	1,595,413		1,595,413	78,441	1,673,854		16
	C. General Administration										
17	Administrative	130,159	131	159,656	289,946		289,946	(159,656)	130,290		17
18	Directors Fees										18
19	Professional Services			80,730	80,730		80,730	(2,874)	77,856		19
20	Dues, Fees, Subscriptions & Promotions			15,228	15,228		15,228	857	16,085		20
21	Clerical & General Office Expenses	161,119	16,120	37,409	214,648		214,648	5,522	220,170		21
22	Employee Benefits & Payroll Taxes			264,652	264,652		264,652		264,652		22
23	Inservice Training & Education			332	332		332		332		23
24	Travel and Seminar			95	95		95	16,652	16,747		24
25	Other Admin. Staff Transportation			31,106	31,106		31,106	1,062	32,168		25
26	Insurance-Prop.Liab.Malpractice			47,694	47,694		47,694	1,502	49,196		26
27	Other (specify):* Benefit Alloc.							17,508	17,508		27
28	TOTAL General Administration	291,278	16,251	636,902	944,431		944,431	(119,427)	825,004		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,971,090	273,035	999,940	3,244,065		3,244,065	(40,409)	3,203,656		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.

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V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7**	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	D. Ownership										
30	Depreciation			10,442	10,442	10,442	124,562	135,004			30
31	Amortization of Pre-Op. & Org.										31
32	Interest			92,360	92,360	92,360	252,809	345,169			32
33	Real Estate Taxes			78,385	78,385	78,385		78,385			33
34	Rent-Facility & Grounds			488,000	488,000	488,000	(482,123)	5,877			34
35	Rent-Equipment & Vehicles			25,846	25,846	25,846	1,415	27,261			35
36	Other (specify):*										36
37	TOTAL Ownership			695,033	695,033	695,033	(103,337)	591,696			37
	Ancillary Expense										
	E. Special Cost Centers										
38	Medically Necessary Transportation										38
39	Ancillary Service Centers		73,332		73,332	73,332		73,332			39
40	Barber and Beauty Shops										40
41	Coffee and Gift Shops										41
42	Provider Participation Fee			65,700	65,700	65,700		65,700			42
43	Other (specify):* Non-allowable cost	35,699	3,263	6,713	45,675	45,675	(45,675)				43
44	TOTAL Special Cost Centers	35,699	76,595	72,413	184,707	184,707	(45,675)	139,032			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,006,789	349,630	1,767,386	4,123,805	4,123,805	(189,421)	3,934,384			45

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

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VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(19,904)	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(41,151)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See PG5A	(17,368)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (78,423)		\$	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)	(110,998)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (110,998)		36
(sum of SUBTOTALS)				
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (189,421)		37

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

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

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

BHF USE ONLY							
48		49		50		51	
							52

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NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Non-allowable Lab expense	\$ (3,311)	43	1
2	Non-allowable X-Ray expense	(835)	43	2
3	Penalties	(1,707)	43	3
4	Offset Other Income	(315)	21	4
5	Non-allowable legal	(11,200)	19	5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(17,368)		49

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VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Suzanne Koenig	51	See Attached		SAK Management		
Melvin Siegel	49	See Attached		Management Svcs	Chicago	Management Co.
				Parkview Terrace		
				Properties, LLC	Skokie	Building Company
				Mavin Enterprises		
				LTD	Skokie	Bookkeeping

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	30 Depreciation	\$	Parkview Terrace Properties, LLC	100.00%	\$ 143,307	\$	143,307
2	V							2
3	V	32 Interest		Parkview Terrace Properties, LLC	100.00%	251,979		251,979
4	V	34 Rent-Facility & Grounds	488,000	Parkview Terrace Properties, LLC	100.00%			(488,000)
5	V							5
6	V							6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 488,000			\$ 395,286	\$ *	(92,714)

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

SEE ACCOUNTANTS' COMPILATION REPORT

**Related Nursing Homes
As of 12/31/08**

Schedule 6A

Group Name	Facility Name	City
SAK Management	Lena Living Center	Lena
	The Lincoln Home	Belleville
	St. Anthony's Nursing & Rehab Ctr	Rock Island
	Thornton Heights Terrace	Chicago Heights
	Coventry Living Center, LLC	Sterling
	Parkview Terrace	East Moline
	Walnut Grove Village, LLC	Morris
	Woodbine Nursing Home, LLC	Oak Park

See Accountants' Compilation Report

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VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	5 Utilities	\$	SAK Management Services, LLC	51.00%	\$ 577	\$ 577	15
16	V	10 Nursing		SAK Management Services, LLC	51.00%	78,441	78,441	16
17	V	17 Administrative	159,656	SAK Management Services, LLC	51.00%		(159,656)	17
18	V	19 Professional Services	385	SAK Management Services, LLC	51.00%	8,711	8,326	18
19	V	20 Dues, Fees & Subscriptions		SAK Management Services, LLC	51.00%	857	857	19
20	V	21 Clerical & General		SAK Management Services, LLC	51.00%	5,837	5,837	20
21	V	23 Inservice Training & Education		SAK Management Services, LLC	51.00%	311	311	21
22	V	24 Travel & Seminar		SAK Management Services, LLC	51.00%	16,652	16,652	22
23	V	25 Other Admin. Staff Transportation		SAK Management Services, LLC	51.00%	751	751	23
24	V	26 Insurance - Property & Liability		SAK Management Services, LLC	51.00%	1,502	1,502	24
25	V	27 Employee Benefits - Mgmt. Co.		SAK Management Services, LLC	51.00%	17,508	17,508	25
26	V	30 Depreciation		SAK Management Services, LLC	51.00%	1,159	1,159	26
27	V	34 Rent - Facility & Grounds		SAK Management Services, LLC	51.00%	5,877	5,877	27
28	V	35 Rent - Eqpt. & Vehicles		SAK Management Services, LLC	51.00%	1,415	1,415	28
29	V	43 Other		SAK Management Services, LLC	51.00%	1,329	1,329	29
30	V	32 Interest		SAK Management Services, LLC	51.00%	830	830	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		\$ 160,041			\$ 141,757	\$ * (18,284)	39

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

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VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference
						Hours	Percent	Description	Amount	
1	N/A								\$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13								TOTAL	\$	13

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

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VIII. ALLOCATION OF INDIRECT COSTS

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

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

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	Utilities	SAK Mgmt. Fees	1,513,288	7	\$ 6,164	\$ 141,756	\$ 577	1
2	10	Nursing	SAK Mgmt. Fees	1,513,288	7	837,385	141,756	78,441	2
3	19	Professional Services	SAK Mgmt. Fees	1,513,288	7	92,992	141,756	8,711	3
4	20	Dues, Fees & Subscriptions	SAK Mgmt. Fees	1,513,288	7	9,149	141,756	857	4
5	21	Clerical & General	SAK Mgmt. Fees	1,513,288	7	62,308	141,756	5,837	5
6	23	Inservice Training & Education	SAK Mgmt. Fees	1,513,288	7	3,317	141,756	311	6
7	24	Travel & Seminar	SAK Mgmt. Fees	1,513,288	7	177,763	141,756	16,652	7
8	25	Other Admin. Staff Transportation	SAK Mgmt. Fees	1,513,288	7	8,017	141,756	751	8
9	26	Insurance - Property & Liability	SAK Mgmt. Fees	1,513,288	7	16,036	141,756	1,502	9
10	27	Employee Benefits - Mgmt. Co.	SAK Mgmt. Fees	1,513,288	7	186,903	141,756	17,508	10
11	30	Depreciation	SAK Mgmt. Fees	1,513,288	7	12,368	141,756	1,159	11
12	34	Rent - Facility & Grounds	SAK Mgmt. Fees	1,513,288	7	62,736	141,756	5,877	12
13	35	Rent - Eqpt. & Vehicles	SAK Mgmt. Fees	1,513,288	7	15,106	141,756	1,415	13
14	43	Other	SAK Mgmt. Fees	1,513,288	7	14,184	141,756	1,329	14
15	32	Interest	SAK Mgmt. Fees	1,513,288	7	8,860	141,756	830	15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 1,513,288	\$ 837,385		\$ 141,757	25

SEE ACCOUNTANTS' COMPILATION REPORT

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 27,040 B. General Construction Type: Exterior Brick Frame Wood 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>334,546</u>	1
2					2
3	TOTALS			\$ <u>334,546</u>	3

SEE ACCOUNTANTS' COMPILATION REPORT

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XI. OWNERSHIP COSTS (continued)

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

	1		2	3	4	5	6	7	8	9	
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	120		2005		\$ 2,770,922	\$	27.5	\$ 100,751	\$ 100,751	\$ 474,386	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9		A-WING PAINTING & REFURBISHING OF RESIDENT ROOMS		2002	6,000		5			6,000	9
10		PAINTING & DECORATING		2003	30,000		5			30,000	10
11		INSTALL ALARM SYSTEM		2004	5,451		27.5	198	198	1,031	11
12											12
13		Sprinkler Repairs		2007	12,934		27.5	470	470	1,175	13
14		Construction of Additional Office & Therapy Space		2007	518,672		27.5	18,861	18,861	55,797	14
15		- general construction, electrical, drywall, HVAC, plumbing									15
16		painting									16
17											17
18		Repair for Broken Pipe - Ceiling & Sprinklers		2008	5,581		20	279	279	419	18
19		Call Lighting System		2008	21,874		20	1,094	1,094	1,641	19
20		West Side of Roof Replaced		2008	5,850		20	293	293	439	20
21		Replace Back Porch with Wall and Walkway		2008	6,970		20	349	349	523	21
22		Rooftop A/C Unit		2008	10,458		20	523	523	784	22
23											23
24											24
25		Electical work		2009	10,284		10	514	514	514	25
26											26
27											27
28											28
29											29
30		Current Booked Depreciation Expense				10,442			(10,442)		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

Facility Name & ID Number Parkview Terrace

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67								67
68								68
69								69
70	TOTAL (lines 4 thru 69)	\$ 3,404,996	\$ 10,442		\$ 123,332	\$ 112,890	\$ 572,709	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Parkview Terrace

0045294

Report Period Beginning:

1/1/09

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	\$ 16,774	\$	\$ 1,914	\$ 1,914	10	\$ 10,496	71
72	Current Year Purchases					3		72
73	Fully Depreciated Assets							73
74	<u>Allocation from RE Entity & SAK Mgmt.</u>	<u>240,000</u>		<u>9,758</u>	<u>9,758</u>		<u>69,080</u>	74
75	TOTALS	\$ 256,774	\$	\$ 11,672	\$ 11,672		\$ 79,576	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	<u>Facility</u>	<u>1998 Ford Windstar</u>	<u>2004</u>	\$ 16,050	\$	\$	\$	5	\$ 16,050	76
77	<u>Administrative</u>	<u>2001 Lexus</u>	<u>2004</u>	<u>19,856</u>				5	<u>19,855</u>	77
78										78
79										79
80	TOTALS			\$ 35,906	\$	\$	\$		\$ 35,905	80

E. Summary of Care-Related Assets

	1	2	
	Reference	Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 4,032,222 81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 10,442 82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 135,004 83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 124,562 84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 688,190 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	<u>N/A</u>	\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92	<u>N/A</u>	\$	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:				\$			3
4	Additions							4
5								5
6	Allocated from Mgmt Co.				5,877			6
7	TOTAL				\$ 5,877			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: \$ 27,261 Description: Resp.Eq-\$134;Dish-\$542;Wash/Dry-\$4,425;Copier-\$3,925;Beds-\$485;Nurse Eq-\$16,335;Alloc Mgmt.-\$1,415
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

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

Fiscal Year Ending Annual Rent

12. _____ /2010 \$ _____

13. _____ /2011 \$ _____

14. _____ /2012 \$ _____

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

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

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

	Service	1 Schedule V Line & Column Reference	2		3		4		6 Supplies (Actual or Allocated)	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Outside Practitioner (other than consultant)							
					Units	Cost						
1	Licensed Occupational Therapist	10A(3)	hrs	\$	1,124	\$ 77,588			\$	1,124	\$ 77,588	1
2	Licensed Speech and Language Development Therapist	10A(3)	hrs		279	19,221				279	19,221	2
3	Licensed Recreational Therapist		hrs									3
4	Licensed Physical Therapist	10A(3)	hrs		1,619	111,706				1,619	111,706	4
5	Physician Care		visits									5
6	Dental Care		visits									6
7	Work Related Program		hrs									7
8	Habilitation		hrs									8
9	Pharmacy	39(2)	# of prescripts					66,297			66,297	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs									10
11	Academic Education		hrs									11
12	Other (specify): <u>Oxygen</u>	39(2)						7,035			7,035	12
13	Other (specify): _____											13
14	TOTAL			\$	3,022	\$ 208,515		\$ 73,332		3,022	\$ 281,847	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Parkview Terrace# 0045294Report Period Beginning: 1/1/09Ending: 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*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 200	\$ 200	1
2	Cash-Patient Deposits	14,719	14,719	2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance <u>none</u>)	1,123,375	1,123,375	3
4	Supply Inventory (priced at _____)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	82,560	82,560	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Due from related parties</u>		726,478	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,220,854	\$ 1,947,332	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		334,546	13
14	Buildings, at Historical Cost	44,977	2,770,922	14
15	Leasehold Improvements, at Historical Cost	59,966	634,074	15
16	Equipment, at Historical Cost	62,978	292,680	16
17	Accumulated Depreciation (book methods)	(101,437)	(688,190)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify): _____			22
23	Other(specify): _____			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 66,484	\$ 3,344,032	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,287,338	\$ 5,291,364	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 1,435,359	\$ 1,435,359	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	14,719	14,719	28
29	Short-Term Notes Payable	927,993	927,993	29
30	Accrued Salaries Payable	47,665	47,665	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	93,828	93,828	32
33	Accrued Interest Payable	27,914	67,486	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>See Schedule 17A</u>	114,718	114,718	36
37	<u>See Schedule 17A</u>	300,187	300,187	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 2,962,383	\$ 3,001,955	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	609,452	777,980	39
40	Mortgage Payable		3,700,804	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	_____			43
44	_____			44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 609,452	\$ 4,478,784	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 3,571,835	\$ 7,480,739	46
47	TOTAL EQUITY (page 18, line 24)	\$ (2,284,497)	\$ (2,189,375)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,287,338	\$ 5,291,364	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

Parkview Terrace, LLC
Provider # 0045294
1/1/09-12/31/09

Schedule 17A

XV. Balance Sheet

	Operating	After Consolidation
Line 36-Other Current Liabilities (specify)		
Fed/Fica P/R Tax W/H Employee	(8,356)	(8,356)
Accrued Payroll Taxes-ER	<u>(106,362)</u>	<u>(106,362)</u>
	<u>(114,718)</u>	<u>(114,718)</u>
Line 37-Other Current Liabilities (specify)		
Due to Related Parties	(209,483)	(209,483)
Cost Report Liability-2006	(82,095)	(82,095)
Cost Report Liability-2007	(68,766)	(68,766)
Cost Report Liability-2008	(4,028)	(4,028)
Cost Report Liability-2009	64,185	64,185
	<u>(300,187)</u>	<u>(300,187)</u>

See Accountants' Compilation Report

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (1,353,821)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (1,353,821)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(930,676)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (930,676)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ (2,284,497)	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Parkview Terrace# 0045294Report Period Beginning: 1/1/09Ending: 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	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 2,885,075	1
2	Discounts and Allowances for all Levels	(37,281)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,847,794	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	304,870	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 304,870	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	40,150	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 40,150	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Other Income	315	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 315	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 3,193,129	30

		2	
	Expenses	Amount	
	A. Operating Expenses		
31	General Services	704,221	31
32	Health Care	1,595,413	32
33	General Administration	944,431	33
	B. Capital Expense		
34	Ownership	695,033	34
	C. Ancillary Expense		
35	Special Cost Centers	119,007	35
36	Provider Participation Fee	65,700	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 4,123,805	40
41	Income before Income Taxes (line 30 minus line 40)**	(930,676)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (930,676)	43

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? No If not, please attach a reconciliation.
Entity is cash basis taxpayer

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

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

Facility Name & ID Number Parkview Terrace

0045294

Report Period Beginning:

1/1/09

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	1,984	2,024	\$ 67,313	\$ 33.26	1
2	Assistant Director of Nursing	1,647	1,915	47,392	24.75	2
3	Registered Nurses	5,761	5,498	105,567	19.20	3
4	Licensed Practical Nurses	17,351	18,608	306,548	16.47	4
5	CNAs & Orderlies	50,530	53,723	544,148	10.13	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	3,574	4,025	58,547	14.55	8
9	Activity Director					9
10	Activity Assistants	5,463	5,818	58,576	10.07	10
11	Social Service Workers	3,390	3,569	41,505	11.63	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	14,343	15,375	134,487	8.75	15
16	Dishwashers					16
17	Maintenance Workers	4,925	5,353	85,258	15.93	17
18	Housekeepers	9,959	10,849	108,922	10.04	18
19	Laundry	44,502	5,187	48,775	9.40	19
20	Administrator	2,030	2,080	73,847	35.50	20
21	Assistant Administrator	1,673	1,673	56,312	33.66	21
22	Other Administrative					22
23	Office Manager	1,843	1,900	63,923	33.64	23
24	Clerical	5,237	5,846	97,196	16.63	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,846	2,086	21,900	10.50	31
32	Other Health Care: MDS Coordinator	2,467	2,544	50,874	20.00	32
33	Other(specify) <u>Marketing</u>	2,573	2,708	35,699	13.18	33
34	TOTAL (lines 1 - 33)	181,098	150,781	\$ 2,006,789 *	\$ 13.31	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	77	\$ 3,070	1(3)	35
36	Medical Director	120	18,000	9(3)	36
37	Medical Records Consultant				37
38	Nurse Consultant	15	614	10(3)	38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	27	549	11(3)	44
45	Social Service Consultant	27	549	12(3)	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	266	\$ 22,782		49

C. CONTRACT NURSES

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

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	
Laurie Alumbaugh	Administrator	0%	\$ 73,847	Workers' Compensation Insurance	\$ 63,445	IDPH License Fee	\$	
Shelly Deshane	Assistant Administrator	0%	56,312	Unemployment Compensation Insurance	36,669	Advertising: Employee Recruitment	2,442	
				FICA Taxes	136,700	Health Care Worker Background Check	1,010	
				Employee Health Insurance	26,185	(Indicate # of checks performed <u>216</u>)		
				Employee Meals		Patient Background Checks	131.7	
				Illinois Municipal Retirement Fund (IMRF)*		Illinois Council on Long Term Care	9,264	
				Employee Physicals	74	Miscellaneous Licenses & Fees	432	
				Other Employee Benefits	1,579	Miscellaneous Dues & Subscriptions	500	
						Alloc. Mgmt Co.	857	
						Less: Public Relations Expense	()	
						Non-allowable advertising	()	
						Yellow page advertising	()	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 130,159	TOTAL (agree to Schedule V, line 22, col.8)	\$ 264,652	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 16,085	
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Description			Amount	Description	Line #	Amount	Description	Amount
SAK Management Services, LLC (Eliminated in Schedule V, col. 7)			\$ 159,656	N/A			Out-of-State Travel	\$
							In-State Travel	
							Seminar Expense	95
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 159,656	TOTAL			Alloc. Mgmt Co.	16,652
C. Professional Services								
Vendor/Payee	Type		Amount					
Aronberg Goldgehn Davis & Garmi	Legal		\$ 748				Entertainment Expense ()	
Shaw Gussis Fishman Glantz Wolfsc	Legal		42,318				TOTAL (agree to Sch. V, line 24, col. 8)	
Stahl Cowen Crowley LLC	Legal		81				\$ 16,747	
Winstein, Kavensky & Wallace	Legal		7,902					
McGladrey & Pullen, LLP	Cost Report Prep		5,010					
Richard Peelo & Associates, Inc.	Cost Report Prep		4,200					
RSM McGladrey, Inc.	Tax Return Prep		5,040					
Sharon Lofgren	Billing Service		3,960					
Personnel Planners, Inc.	Human Resources		510					
Bookkeeping Fees	Accounting		385					
HDSI	A/R System Service		5,497					
See Sch 21C			5,079					
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 80,730					

* Attach copy of IMRF notifications

**See instructions.

Parkview Terrace
Provider # 0045294
1/1/09-12/31/09

Schedule XIX.C Professional Services

Schedule 21C

C. Professional Services

<u>Vendor</u>	<u>Type</u>	<u>Amount</u>
LTC Solutions	Software Consulting	1,500
Payday USA	Payroll Processing Services	3,579
		<u>5,079</u>
Total(agree to Schedule V, line 19, column 3)		80,730
Less SAK Bookkeeping Services		(385)
Allocation from SAK-Legal		6,889
Allocation from SAK-Data Processing		1,160
Allocation from SAK-Accounting		215
Allocation from SAK-Computer tech		447
To remove out of period legal		(11,200)
Total (agree to Schedule V, line 19, column 8)		<u>77,856</u>

See Accountants' Compilation Report

Facility Name & ID Number Parkview Terrace

Report Period Beginning: 1/1/09

Ending:

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

(See instructions.)

	1 Improvement Type	2 Month & Year Improvement Was Made	3 Total Cost	4 Useful Life	8 Amount of Expense Amortized Per Year								
					5 FY2006	6 FY2007	7 FY2008	9 FY2009	10 FY2010	11 FY2011	12 FY2012	13 FY2013	14 FY2014
1			\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3								N/A					
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Parkview Terrace# 0045294

Report Period Beginning:

1/1/09Ending: 12/31/09**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? Yes
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. IL Council on Long Term Care-\$9,264
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 3
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 1,119 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 65,700
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? No Indicate the amount. \$ N/A
- (16) Travel and Transportation
- a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
- b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
- c. What percent of all travel expense relates to transportation of nurses and patients? 0
- d. Have vehicle usage logs been maintained? Adequate records have been maintained.
- e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
- f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
- g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? Yes
Attach invoices and a summary of services for all architect and appraisal fees.

SEE ACCOUNTANTS' COMPILATION REPORT