

		FOR BHF USE					

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IMPORTANT NOTICE  
 THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

**2009**  
**STATE OF ILLINOIS**  
**DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES**  
**FINANCIAL AND STATISTICAL REPORT (COST REPORT)**  
**FOR LONG-TERM CARE FACILITIES**  
**(FISCAL YEAR 2009)**

<p><b>I. IDPH License ID Number:</b> <u>0048421</u></p> <p><b>Facility Name:</b> <u>SOUTHVIEW MANOR</u></p> <p><b>Address:</b> <u>3311 SOUTH MICHIGAN AVENUE CHICAGO 60616</u>  <small>Number City Zip Code</small></p> <p><b>County:</b> <u>COOK</u></p> <p><b>Telephone Number:</b> <u>( 847 ) 674-5795</u> Fax # <u>( 847 ) 674-5794</u></p> <p><b>HFS ID Number:</b> <u>352279812-001</u></p> <p><b>Date of Initial License for Current Owners:</b> <u>11/1/06</u></p> <p><b>Type of Ownership:</b></p> <table style="width:100%; border: none;"> <tr> <td style="width:33%; border: none;"> <input type="checkbox"/> VOLUNTARY, NON-PROFIT  <input type="checkbox"/> Charitable Corp.  <input type="checkbox"/> Trust            IRS Exemption Code _____         </td> <td style="width:33%; border: none;"> <input checked="" type="checkbox"/> PROPRIETARY  <input type="checkbox"/> Individual  <input type="checkbox"/> Partnership  <input type="checkbox"/> Corporation  <input type="checkbox"/> "Sub-S" Corp.  <input checked="" type="checkbox"/> Limited Liability Co.  <input type="checkbox"/> Trust  <input type="checkbox"/> Other _____         </td> <td style="width:33%; border: none;"> <input type="checkbox"/> GOVERNMENTAL  <input type="checkbox"/> State  <input type="checkbox"/> County  <input type="checkbox"/> Other _____         </td> </tr> </table> <p><b>In the event there are further questions about this report, please contact:</b>  <b>Name:</b> <u>BOB KAGDA</u> Telephone Number: <u>( 847 ) 675-3585</u>  <b>Email Address:</b> <u>kvanstockum@kbbcpa.com</u></p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT <input type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code _____	<input checked="" type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> "Sub-S" Corp. <input checked="" type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____	<input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____	<p><b>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</b></p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/2009</u> to <u>12/31/2009</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table style="width:100%; border: none;"> <tr> <td style="width:20%; border: none; vertical-align: top;"> <b>Officer or Administrator of Provider</b> </td> <td style="border: none;">           (Signed) _____ (Date) _____            (Type or Print Name) <u>AVRUM WEINFELD</u>            (Title) <u>CEO</u> </td> </tr> <tr> <td style="border: none; vertical-align: top;"> <b>Paid Preparer</b> </td> <td style="border: none;">           (Signed) <u>(SEE ATTACHED ACCOUNTANTS' REPORT)</u> (Date) _____            (Print Name and Title) <u>BOB KAGDA VICE PRESIDENT</u>            (Firm Name &amp; Address) <u>KRUPNICK, BOKOR, KAGDA &amp; BROOKS, LTD 3750 W DEVON, LINCOLNWOOD, IL 60712-1124</u>            (Telephone) <u>( 847 ) 675-3585</u> Fax # <u>( 847 ) 675-5777</u> </td> </tr> </table> <p align="right"> <b>MAIL TO: BUREAU OF HEALTH FINANCE</b>  <b>ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES</b>  <b>201 S. Grand Avenue East</b>  <b>Springfield, IL 62763-0001</b> Phone # (217) 782-1630     </p>	<b>Officer or Administrator of Provider</b>	(Signed) _____ (Date) _____ (Type or Print Name) <u>AVRUM WEINFELD</u> (Title) <u>CEO</u>	<b>Paid Preparer</b>	(Signed) <u>(SEE ATTACHED ACCOUNTANTS' REPORT)</u> (Date) _____ (Print Name and Title) <u>BOB KAGDA VICE PRESIDENT</u> (Firm Name & Address) <u>KRUPNICK, BOKOR, KAGDA &amp; BROOKS, LTD 3750 W DEVON, LINCOLNWOOD, IL 60712-1124</u> (Telephone) <u>( 847 ) 675-3585</u> Fax # <u>( 847 ) 675-5777</u>
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<b>Officer or Administrator of Provider</b>	(Signed) _____ (Date) _____ (Type or Print Name) <u>AVRUM WEINFELD</u> (Title) <u>CEO</u>							
<b>Paid Preparer</b>	(Signed) <u>(SEE ATTACHED ACCOUNTANTS' REPORT)</u> (Date) _____ (Print Name and Title) <u>BOB KAGDA VICE PRESIDENT</u> (Firm Name & Address) <u>KRUPNICK, BOKOR, KAGDA &amp; BROOKS, LTD 3750 W DEVON, LINCOLNWOOD, IL 60712-1124</u> (Telephone) <u>( 847 ) 675-3585</u> Fax # <u>( 847 ) 675-5777</u>							

Facility Name & ID Number SOUTHVIEW MANOR

# 0048421 Report Period Beginning: 01/01/2009 Ending: 12/31/2009

**III. STATISTICAL DATA**

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	74	Skilled (SNF)	74	27,010	1
2		Skilled Pediatric (SNF/PED)			2
3	126	Intermediate (ICF)	126	45,990	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	200	TOTALS	200	73,000	7

**B. Census-For the entire report period.**

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	4,545		4,207	8,752	8
9	SNF/PED					9
10	ICF	61,797		487	62,284	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	66,342		4,694	71,036	14

**C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 97.31%**

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

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

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

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

NONE

**F. Does the facility maintain a daily midnight census?**

YES

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

YES  NO

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

YES  NO

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

Date started 11/01/06

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

YES  Date 11/01/06 NO

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

YES  NO  If YES, enter number

of beds certified 42 and days of care provided 4,207

Medicare Intermediary ADMINISTAR FEDERAL

**IV. ACCOUNTING BASIS**

ACCRUAL  MODIFIED CASH\*  CASH\*

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

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

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

Facility Name &amp; ID Number

SOUTHVIEW MANOR

# 0048421

Report Period Beginning:

01/01/2009

Ending:

12/31/2009

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>A. General Services</b>										
1	Dietary	246,873	37,140	10,091	294,104		294,104		294,104		1
2	Food Purchase		309,945		309,945		309,945	(596)	309,349		2
3	Housekeeping	356,416	63,978		420,394		420,394	6,199	426,593		3
4	Laundry	54,320	17,870	6,059	78,249		78,249		78,249		4
5	Heat and Other Utilities			145,576	145,576		145,576		145,576		5
6	Maintenance	113,051	56,020	60,145	229,216		229,216	5,368	234,584		6
7	Other (specify):* SECURITY	182,402		23,315	205,717		205,717	71	205,788		7
8	<b>TOTAL General Services</b>	953,062	484,953	245,186	1,683,201		1,683,201	11,042	1,694,243		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			2,400	2,400		2,400		2,400		9
10	Nursing and Medical Records	2,133,815	55,833	19,200	2,208,848		2,208,848		2,208,848		10
10a	Therapy	20,809		32,371	53,180		53,180		53,180		10a
11	Activities	111,993	11,890	3,064	126,947		126,947		126,947		11
12	Social Services	319,658		2,075	321,733		321,733		321,733		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	2,586,275	67,723	59,110	2,713,108		2,713,108		2,713,108		16
	<b>C. General Administration</b>										
17	Administrative	108,611		74,178	182,789		182,789	62,752	245,541		17
18	Directors Fees										18
19	Professional Services			52,850	52,850		52,850	7,959	60,809		19
20	Dues, Fees, Subscriptions & Promotions			19,154	19,154		19,154	(2,497)	16,657		20
21	Clerical & General Office Expenses	259,779	34,827	68,437	363,043		363,043	(32,524)	330,519		21
22	Employee Benefits & Payroll Taxes			681,140	681,140		681,140		681,140		22
23	Inservice Training & Education							16	16		23
24	Travel and Seminar			1,622	1,622		1,622		1,622		24
25	Other Admin. Staff Transportation			2,950	2,950		2,950	878	3,828		25
26	Insurance-Prop.Liab.Malpractice			98,217	98,217		98,217	1,278	99,495		26
27	Other (specify):*			260,571	260,571		260,571	(246,343)	14,228		27
28	<b>TOTAL General Administration</b>	368,390	34,827	1,259,119	1,662,336		1,662,336	(208,481)	1,453,855		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	3,907,727	587,503	1,563,415	6,058,645		6,058,645	(197,439)	5,861,206		29

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

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

V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE	SCHED REF	TOTAL
<b>1</b>	<b>DIETARY</b>	
	DIETITIAN CONSULTANT XVIII B 35-2	10,091
	REPAIRS & MAINTENANCE	0
		0
		10,091
<b>3</b>	<b>HOUSEKEEPING</b>	
		0
		0
		0
<b>4</b>	<b>LAUNDRY</b>	
	EQUIPMENT REPAIRS & MAINTENANCE	6,059
		0
		6,059
<b>5</b>	<b>HEAT &amp; OTHER UTILITIES</b>	
	GAS HEAT	67,023
	ELECTRICITY	57,600
	WATER	6,071
	CABLE TV - LOBBY	14,882
		0
		145,576
<b>6</b>	<b>MAINTENANCE</b>	
	GROUNDS MAINTENANCE	1,066
	PAINTING & DECORATING	0
	BUILDING REPAIRS	0
	MAINTENANCE TRAVEL	0
	EQUIPMENT MAINTENANCE & REPAIR	22,608
	ELEVATOR MAINTENANCE & REPAIR	22,545
	OUTSIDE LABOR	0
	EXTERMINATING SERVICE	2,398
	FIRE SERVICE	11,528
		0
		0
		0
		0
		60,145
<b>7</b>	<b>OTHER</b>	
	SCAVENGER	23,315
	SECURITY SERVICE	0
		0
		0
		23,315
<b>9</b>	<b>MEDICAL DIRECTOR</b>	
	MEDICAL DIRECTOR FEES XVIII B 36-2	2,400
		2,400

LINE	SCHED REF	TOTAL
<b>10</b>	<b>NURSING</b>	
	CONTRACT NURSING XVIII C 53-2	
	LABORATORY & XRAY EXPENSE	0
	PURCHASED SERVICES	0
	PSYCHO-SOCIAL CONSULTANT XVIII B ___-2	0
	RESTORATIVE NURSING CONSULTANT XVIII B 38-2	0
	MEDICAL RECORDS CONSULTANT XVIII B 37-2	0
	PHARMACY CONSULTANT XVIII B 39-2	9,600
	UTILIZATION REVIEW FEES XVIII B ___-2	0
	PHYSICIANS XVIII B ___-2	0
	PSYCHIATRIC XVIII B ___-2	4,800
	RN CONSULTANT XVIII B 38-2	0
	DENTAL CONSULTANT	4,800
		0
		19,200
<b>10a</b>	<b>THERAPY</b>	
	PHYSICAL THERAPY SERVICES	
	SPEECH THERAPY SERVICES	111
	OCCUPATIONAL THERAPY SERVICES	0
	REHABILITATION CONSULTANT XVIII B ___-2	0
	PHYSICAL THERAPY CONSULTANT XVIII B 40-2	760
	OCCUPATIONAL THERAPY CONSULTA XVIII B 41-2	0
	RESPIRATORY THERAPY CONSULTAN XVIII B 42-2	31,500
	SPEECH THERAPY CONSULTANT XVIII B 43-2	0
		32,371
<b>11</b>	<b>ACTIVITIES</b>	
	CABLE TV - PATIENT ROOMS	
	ACTIVITY REHAB CONSULTANT XVIII B 44-2	3,064
		0
		3,064
<b>12</b>	<b>SOCIAL SERVICES</b>	
	SOCIAL REHABILITATION SERVICES	
	SOCIAL REHABILITATION CONSULTAN XVIII B 45-2	2,075
	SOCIAL WORKER XVIII B 45-2	0
		0
		2,075
<b>13</b>	<b>NURSE AIDE TRAINING</b>	
	NURSE AIDE TRAINING COSTS XIII	0
		0

V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE	SCHED REF	TOTAL
14	<b>PROGRAM TRANSPORTATION</b>	
	PATIENT TRANSPORTATION	0
		0
17	<b>ADMINISTRATIVE</b>	
	MANAGEMENT FEES XIX B	74,178
	<b>DIRECTORS FEES</b>	
18	DIRECTORS FEES	0
19	<b>PROFESSIONAL SERVICES</b>	
	DATA PROCESSING XIX C	21,845
	ADMINISTRATIVE CONSULTANTS XIX C	0
	PROFESSIONAL FEES XIX C	31,005
		0
		52,850
20	<b>FEES,SUBSCRIPTIONS,PROMOTIONS</b>	
	ENTERTAINMENT & MARKETING VI 19 XIX F	0
	ADV & PROMO-NON PATIENT RELATED VI 25 XIX F	2,822
	EMPLOYEE WANT ADS XIX F	0
	CONTRIBUTIONS VI 20 XIX F	500
	DUES & SUBSCRIPTIONS XIX F	9,173
	LICENSES & PERMITS XIX F	3,915
	PUBLIC RELATIONS-PATIENT RELATED XIX F	0
	ADVERTISING-YELLOW PAGES VI 28 XIX F	0
	TRUST FEES / FRANCHISE TAX / ETC VI 17 XIX F	0
	CONTRIBUTIONS - POLITICAL VI 20 XIX F	2,744
	HEALTH CARE WORKER BACKGROUND CHEC XIX F	0
	PATIENT BACKGROUND CHECKS XIX F	0
		19,154
21	<b>CLERICAL &amp; GENERAL OFFICE EXPENSES</b>	
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)	4,766
	EQUIPMENT REPAIR & MAINTENANCE	0
	OUTSIDE CLERICAL SERVICES	9,000
	PENALTIES / OVERDRAFT CHARGES VI 18	21,625
	HOME OFFICE EXPENSE	0
	THEFT & DAMAGE LOSS	0
	TELEPHONE	32,204
	MESSENGER SERVICE	0
	STAFF DEVELOPMENT	842
		68,437

LINE	SCHED REF	TOTAL
22	<b>EMPLOYEE BENEFITS &amp; PAYROLL TAXES</b>	
	FICA TAXES XIX D	298,189
	UNEMPLOYMENT COMPENSATION XIX D	65,567
	WORKERS COMPENSATION INSURANCE XIX D	87,302
	HOSPITALIZATION INSURANCE XIX D	218,109
	EMPLOYEE BENEFITS - OTHER XIX D	4,257
	EMPLOYEE PHYSICAL EXAMS XIX D	0
	INSURANCE - EXECUTIVE LIFE VI 21/XIX D	0
	PENSION/PROFIT SHARING PLANS XIX D	0
	CHICAGO HEAD TAX XIX D	7,716
		0
		681,140
23	<b>INSERVICE TRAINING &amp; EDUCATION</b>	
	EDUCATION & SEMINARS	0
		0
24	<b>TRAVEL &amp; SEMINARS</b>	
	EDUCATION & SEMINARS XIX G	1,622
	TRAVEL XIX G	0
		1,622
25	<b>ADMIN. STAFF TRANSPORTATION</b>	
	TRANSPORTATION - STAFF	2,950
		2,950
26	<b>INSURANCE - PROP. LIAB &amp; MALPRACTICE</b>	
	GENERAL INSURANCE	98,217
		98,217
27	<b>OTHER</b>	
	BAD DEBTS VI 24	260,571
		260,571

GRAND TOTAL COLUMN 3 OTHER

1,563,415

**SOUTHVIEW MANOR  
SCHEDULES  
12/31/2009**

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

TOTAL FOOD PURCHASE	309,945
LESS SALES TAX	<u>(596)</u>
NET FOOD	309,349

TOTAL PATIENT CENSUS	71,036
TIME 3 MEALS PER DAY	<u>3</u>
TOTAL PATIENT MEALS	213,108

ADD # EMPLOYEE MEALS/DAY	0
TIME # DAYS	<u>365</u>
TOTAL EMPLOYEE MEALS	0

PATIENT MEALS	213,108
ADD EMPLOYEE MEALS	<u>0</u>
TOTAL MEALS/YEAR	213,108

NET FOOD	309,349
DIVIDE TOTAL MEALS/YEAR	<u>213,108</u>

COST PER MEAL	1.45
TIME EMPLOYEE MEALS	<u>0</u>
EMPLOYEE MEAL RECLASSIFICATION	<b>0</b>
	=====

Facility Name &amp; ID Number

SOUTHVIEW MANOR

#0048421

Report Period Beginning:

01/01/2009

Ending:

12/31/2009

## 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			42,098	42,098		42,098	(30,192)	11,906			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			30,669	30,669		30,669	(43,311)	(12,642)			32
33	Real Estate Taxes			248,081	248,081		248,081		248,081			33
34	Rent-Facility & Grounds			1,642,458	1,642,458		1,642,458		1,642,458			34
35	Rent-Equipment & Vehicles			68,543	68,543		68,543	2,162	70,705			35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			2,031,849	2,031,849		2,031,849	(71,341)	1,960,508			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		146,776	53,109	199,885		199,885		199,885			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			109,500	109,500		109,500		109,500			42
43	Other (specify):*											43
44	<b>TOTAL Special Cost Centers</b>		146,776	162,609	309,385		309,385		309,385			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	3,907,727	734,279	3,757,873	8,399,879		8,399,879	(268,780)	8,131,099			45

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

**VI. ADJUSTMENT DETAIL**

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

		1	2	3	
	<b>NON-ALLOWABLE EXPENSES</b>	<b>Amount</b>	<b>Refer- ence</b>	<b>BHF USE ONLY</b>	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(30,403)	30		9
10	Interest and Other Investment Income	(43,311)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(596)	2		13
14	Non-Care Related Interest		32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees		20		17
18	Fines and Penalties	(21,625)	21		18
19	Entertainment		20		19
20	Contributions	(3,244)	20		20
21	Owner or Key-Man Insurance		22		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(260,571)	27		24
25	Fund Raising, Advertising and Promotional	(2,822)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising		20		28
29	Other-Attach Schedule	(38,213)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (400,785)		\$	30

<b>BHF USE ONLY</b>							
48		49		50		51	
							52

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

		1	2	
		<b>Amount</b>	<b>Reference</b>	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	132,005		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ 132,005		36
37	<b>TOTAL ADJUSTMENTS (A) and (B)</b>	\$ (268,780)		37

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

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

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

ID# 0048421  
Report Period Beginning: 01/01/2009  
Ending: 12/31/2009

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	Sch. V Line
1	DEFERRED MAINTENANCE	\$ 0	6	1
2	MARKETING SALARIES	(31,428)	21	2
3	BANK CHARGE	(4,766)	21	3
4	STAFF DEVELOPMEMT	(842)	21	4
5	MARKETING AUTO LEASE	(1,177)	35	5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	<b>Total</b>	(38,213)		49

## STATE OF ILLINOIS

Summary A

Facility Name & ID Number SOUTHVIEW MANOR# 0048421

Report Period Beginning:

01/01/2009

Ending:

12/31/2009

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(596)	0	0	0	0	0	0	0	0	0	0	(596)	2
3	Housekeeping	0	0	0	6,199	0	0	0	0	0	0	0	6,199	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	3,192	2,176	0	0	0	0	0	0	0	5,368	6
7	Other (specify):*	0	0	0	71	0	0	0	0	0	0	0	71	7
8	<b>TOTAL General Services</b>	<b>(596)</b>	<b>0</b>	<b>3,192</b>	<b>8,446</b>	<b>0</b>	<b>11,042</b>	<b>8</b>						
	<b>B. Health Care and Programs</b>													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	<b>TOTAL Health Care and Programs</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative	0	81,628	(28,518)	9,642	0	0	0	0	0	0	0	62,752	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	92	574	7,293	0	0	0	0	0	0	0	7,959	19
20	Fees, Subscriptions & Promotions	(6,066)	0	0	3,569	0	0	0	0	0	0	0	(2,497)	20
21	Clerical & General Office Expenses	(58,661)	0	7,910	18,227	0	0	0	0	0	0	0	(32,524)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	16	0	0	0	0	0	0	0	16	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	275	603	0	0	0	0	0	0	0	878	25
26	Insurance-Prop.Liab.Malpractice	0	0	1,037	241	0	0	0	0	0	0	0	1,278	26
27	Other (specify):*	(260,571)	0	9,026	5,202	0	0	0	0	0	0	0	(246,343)	27
28	<b>TOTAL General Administration</b>	<b>(325,298)</b>	<b>81,720</b>	<b>(9,696)</b>	<b>44,793</b>	<b>0</b>	<b>(208,481)</b>	<b>28</b>						
29	<b>TOTAL Operating Expense</b> (sum of lines 8,16 & 28)	<b>(325,894)</b>	<b>81,720</b>	<b>(6,504)</b>	<b>53,239</b>	<b>0</b>	<b>(197,439)</b>	<b>29</b>						

## STATE OF ILLINOIS

Summary B

Facility Name & ID Number SOUTHVIEW MANOR# 0048421

Report Period Beginning:

01/01/2009 Ending:

12/31/2009

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

	Capital Expense	PAGES	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	(30,403)	0	64	147	0	0	0	0	0	0	0	(30,192) 30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0 31
32	Interest	(43,311)	0	0	0	0	0	0	0	0	0	0	(43,311) 32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0 33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0 34
35	Rent-Equipment & Vehicles	(1,177)	0	524	2,815	0	0	0	0	0	0	0	2,162 35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0 36
37	<b>TOTAL Ownership</b>	<b>(74,891)</b>	<b>0</b>	<b>588</b>	<b>2,962</b>	<b>0</b>	<b>(71,341) 37</b>						
	<b>Ancillary Expense</b>												
	<b>E. Special Cost Centers</b>												
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0 38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0 39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0 40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0 41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0 42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0 43
44	<b>TOTAL Special Cost Centers</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0 44</b>
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	<b>(400,785)</b>	<b>81,720</b>	<b>(5,916)</b>	<b>56,201</b>	<b>0</b>	<b>(268,780) 45</b>						

**VII. RELATED PARTIES**

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
SEE ATTACHED SCHEDULE		SEE ATTACHED SCHEDULE		6865 FIN. INC	LINCOLNWOOD	MANAGEMENT
SEE ATTACHED SCHEDULE		SEE ATTACHED SCHEDULE		EMI ENTERPRISE	LINCOLNWOOD	MANAGEMENT
SEE ATTACHED SCHEDULE		SEE ATTACHED SCHEDULE		EKS MGMT	LINCOLNWOOD	BOOKKEEPING
SEE ATTACHED SCHEDULE		SEE ATTACHED SCHEDULE		IME REALTY	LINCOLNWOOD	HOME OFFICE
SEE ATTACHED SCHEDULE		SEE ATTACHED SCHEDULE				
SEE ATTACHED SCHEDULE		SEE ATTACHED SCHEDULE				

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	17	\$ 74,178	6865 FINANCIAL INC		\$	(74,178)	1
2	V	17				22,500	22,500	2
3	V	17				52,209	52,209	3
4	V	17				61,702	61,702	4
5	V	17				3,955	3,955	5
6	V	17				15,440	15,440	6
7	V	19				92	92	7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 74,178			\$ 155,898	\$ * 81,720	14

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	17 MANAGEMENT FEE	\$ 52,209	EMI ENTERPRISES, INC.		\$	\$ (52,209)
16	V	6 DRIVERS SALARIES				3,192	3,192
17	V	17 M. ESFORMES - OFFICER				16,353	16,353
18	V	17 REGIONAL DIRECTOR				7,338	7,338
19	V	19 ACCOUNTING FEES				574	574
20	V	21 OFFICE				7,910	7,910
21	V	25 TRANSPORTATION				275	275
22	V	26 INSURANCE				1,037	1,037
23	V	27 EMPLOYEE BENEFITS				9,026	9,026
24	V	30 DEPRECIATION S/L				64	64
25	V	35 AUTO LEASE				524	524
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 52,209			\$ 46,293	\$ * (5,916)

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

Facility Name & ID Number SOUTHVIEW MANOR# 0048421Report Period Beginning: 01/01/2009 Ending: 12/31/2009

## VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	21	OUTSIDE CLERICAL	\$ 9,000	EKS MANAGEMENT INC		\$ (9,000)
16	V	3	HOUSEKEEPING SALARIES			6,199	6,199
17	V	6	PAINTERS SALARIES			2,176	2,176
18	V	7	SCAVENGER			71	71
19	V	17	CFO - SALARY			9,642	9,642
20	V	19	PROFESSIONAL FEES			7,293	7,293
21	V	20	WANT ADS / BACKGR CKS			3,569	3,569
22	V	21	OFFICE			27,227	27,227
23	V	23	SEMINARS			16	16
24	V	25	TRANSPORTATION			603	603
25	V	26	INSURANCE			241	241
26	V	27	EMPLOYEE BENEFITS			5,202	5,202
27	V	30	DEPRECIATION S/L			147	147
28	V	35	EQUIPMENT RENT			2,815	2,815
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 9,000			\$ 65,201	\$ * 56,201

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

Facility Name &amp; ID Number

SOUTHVIEW MANOR

#

0048421

Report Period Beginning:

01/01/2009

Ending:

12/31/2009

## VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	SHELDON NEIDICH	ADMINISTRATIVE						COMP 6865	\$ 22,500	17-7	1
2											2
3	MORRIS ESFORMES	ADMINISTRATIVE						COMP EMI	16,353	17-7	3
4					SEE			ADM CONS		19-3	4
5	PHILIP ESFORMES	ADMINISTRATIVE			ATTACHED			COMP 6865	61,702	17-7	5
6					SCHEDULE						6
7	DANIEL WEISS	ADMINISTRATIVE						COMP 6865	3,955	17-7	7
8											8
9	FLORA WEISS	CLERICAL						COMP EKS	1,403	21-7	9
10											10
11	AVRUM WEINFELD	ADMINISTRATIVE						COMP 6865	15,440	17-7	11
12								COMP EKS	9,642	17-7	12
13								TOTAL	\$ 130,995		13

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

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

Facility Name & ID Number SOUTHVIEW MANOR

# 0048421

Report Period Beginning:

01/01/2009

Ending: 2/31/2009

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	17	SHELDON NEIDICH	DIRECT	1	\$ 22,500	\$ 22,500	1	\$ 22,500	1
2	17	EMI ENTERPRISES	PATIENT DAYS	538,796	396,000	71,036	52,209	2	2
3	17	PHILIP ESFORMES INC	PATIENT DAYS	538,796	468,000	71,036	61,702	3	3
4	17	DANIEL WEISS	PATIENT DAYS	538,796	30,000	71,036	3,955	4	4
5	17	AVRUM WEINFELD	PATIENT DAYS	538,796	117,111	71,036	15,440	5	5
6	19	ACCOUNTING FEES	PATIENT DAYS	538,796	700	71,036	92	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				\$ 1,034,311	\$ 637,611		\$ 155,898	25

Facility Name & ID Number SOUTHVIEW MANOR

# 0048421

Report Period Beginning:

01/01/2009

Ending: 2/31/2009

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	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	6	DRIVERS SALARIES	PATIENT DAYS	847,051	14	\$ 38,060	\$ 71,036	\$ 3,192	1
2	17	M. ESFORMES - OFFICER	PATIENT DAYS	847,051	14	195,000	71,036	16,353	2
3	17	REGIONAL DIRECTOR	PATIENT DAYS	847,051	14	87,500	71,036	7,338	3
4	19	ACCOUNTING FEES	PATIENT DAYS	847,051	14	6,850	71,036	574	4
5	21	OFFICE	PATIENT DAYS	847,051	14	94,319	71,036	7,910	5
6	25	TRANSPORTATION	PATIENT DAYS	847,051	14	3,276	71,036	275	6
7	26	INSURANCE	PATIENT DAYS	847,051	14	12,367	71,036	1,037	7
8	27	EMPLOYEE BENEFITS	PATIENT DAYS	847,051	14	107,628	71,036	9,026	8
9	30	DEPRECIATION S/L	PATIENT DAYS	847,051	14	765	71,036	64	9
10	35	AUTO LEASE	PATIENT DAYS	847,051	14	6,253	71,036	524	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					\$ 552,018	\$ 378,811	\$ 46,293	25

Facility Name & ID Number SOUTHVIEW MANOR

# 0048421

Report Period Beginning:

01/01/2009

Ending: 2/31/2009

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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	3	HOUSEKEEPING SALARIES	PATIENT DAYS	847,051	14	\$ 73,923	\$ 73,923	71,036	\$ 6,199	1
2	6	PAINTERS SALARIES	PATIENT DAYS	847,051	14	25,953	25,953	71,036	2,176	2
3	7	SCAVENGER	PATIENT DAYS	847,051	14	842		71,036	71	3
4	17	CFO - SALARY	PATIENT DAYS	847,051	14	114,971	114,971	71,036	9,642	4
5	19	PROFESSIONAL FEES	PATIENT DAYS	847,051	14	86,967	74,170	71,036	7,293	5
6	20	WANT ADS / BACKGR CKS	PATIENT DAYS	847,051	14	42,556		71,036	3,569	6
7	21	OFFICE	PATIENT DAYS	847,051	14	324,660	246,961	71,036	27,227	7
8	23	SEMINARS	PATIENT DAYS	847,051	14	190		71,036	16	8
9	25	TRANSPORTATION	PATIENT DAYS	847,051	14	7,194		71,036	603	9
10	26	INSURANCE	PATIENT DAYS	847,051	14	2,872		71,036	241	10
11	27	EMPLOYEE BENEFITS	PATIENT DAYS	847,051	14	62,031		71,036	5,202	11
12	30	DEPRECIATION S/L	PATIENT DAYS	847,051	14	1,757		71,036	147	12
13	35	EQUIPMENT RENT	PATIENT DAYS	847,051	14	33,562		71,036	2,815	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					\$ 777,478	\$ 535,978		\$ 65,201	25

Facility Name & ID Number SOUTHVIEW MANOR

# 0048421

Report Period Beginning:

01/01/2009

Ending:

12/31/2009

**IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE**

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

1	2	3	4	5	6	7	8	9	10										
										Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
										YES	NO				Original	Balance			
<b>A. Directly Facility Related</b>																			
<b>Long-Term</b>																			
1																			
2																			
3																			
4																			
5																			
<b>Working Capital</b>																			
6		X	WORKING CAPITAL	INTEREST	REVOLV		220,000	REVOLLV	PRIME +	30,669									
7																			
8																			
9							\$ 220,000			\$ 30,669									
<b>B. Non-Facility Related*</b>																			
10		X	LATE FEES																
11																			
12																			
13																			
14							\$			\$									
15							\$ 220,000			\$ 30,669									

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

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

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

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

**B. Real Estate Taxes**

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

1. Real Estate Tax accrual used on 2008 report.		\$	<b>240,814</b>	<b>1</b>
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		\$	<b>243,230</b>	<b>2</b>
3. Under or (over) accrual (line 2 minus line 1).		\$	<b>2,416</b>	<b>3</b>
4. Real Estate Tax accrual used for 2009 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	<b>245,665</b>	<b>4</b>
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>		\$		<b>5</b>
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. <b>TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>		\$		<b>6</b>
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	<b>248,081</b>	<b>7</b>

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2004	<b>208,985</b>	<b>8</b>
	2005	<b>211,113</b>	<b>9</b>
	2006	<b>243,413</b>	<b>10</b>
	2007	<b>240,814</b>	<b>11</b>
	2008	<b>243,230</b>	<b>12</b>

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

**NOTES:**

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

**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 SOUTHVIEW MANOR COUNTY COOK

FACILITY IDPH LICENSE NUMBER 0048421

CONTACT PERSON REGARDING THIS REPORT BOB KAGDA

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

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

Enter the tax index number and real estate tax assessed for 2008 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 2008.

(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u>17-34-116-003-0000</u>	<u>NURSING HOME</u>	\$ <u>84,312.22</u>	\$ <u>84,312.22</u>
2. <u>17-34-116-004-0000</u>	<u>NURSING HOME</u>	\$ <u>47,954.12</u>	\$ <u>47,954.12</u>
3. <u>17-34-116-005-0000</u>	<u>NURSING HOME</u>	\$ <u>36,357.96</u>	\$ <u>36,357.96</u>
4. <u>17-34-116-006-0000</u>	<u>NURSING HOME</u>	\$ <u>36,357.96</u>	\$ <u>36,357.96</u>
5. <u>17-34-116-007-0000</u>	<u>NURSING HOME</u>	\$ <u>36,357.96</u>	\$ <u>36,357.96</u>
6. <u>17-34-116-008-0000</u>	<u>NURSING HOME</u>	\$ <u>1,889.94</u>	\$ <u>1,889.94</u>
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ <u>243,230.16</u>	\$ <u>243,230.16</u>

**B. Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES X NO

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

**C. Tax Bills**

Attach a copy of the original 2008 tax bills which were listed in Section A to this statement. Be sure to use the 2008 tax bill which is normally paid during 2009.

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



**XI. OWNERSHIP COSTS (continued)**

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

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8		RELATED PARTY - HOME OFFICE			46,019						8
		Improvement Type**									
9		ELEVATOR REPAIR	2007		19,816	721	27.5	721		1,953	9
10		TELEPHONE SYSTEM	2007		13,100	476	27.5	476		1,408	10
11		WATER HEATER	2007		32,500	1,182	27.5	1,182		3,201	11
12		ROOF REPAIR	2008		14,800	538	27.5	538		785	12
13		60 TON CHILLER	2008		71,075	2,585	27.5	2,585		3,769	13
14		PUMP GASKETS, OIL TANK COOLERS	2008		9,115	331	27.5	331		400	14
15		OIL COOLERS, PUMP SEALS	2008		19,285	702	27.5	702		848	15
16		AWNING	2008		3,000	109	27.5	109		132	16
17		FENCE	2008		3,960	264	15	264		396	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

Facility Name & ID Number SOUTHVIEW MANOR

# 0048421

Report Period Beginning:

01/01/2009 Ending:

12/31/2009

**XI. OWNERSHIP COSTS (continued)**

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

1	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	<b>TOTAL (lines 4 thru 69)</b>		\$ 232,670	\$ 6,908		\$ 6,908	\$	\$ 12,892	70

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

Facility Name & ID Number **SOUTHVIEW MANOR**

# **0048421**

Report Period Beginning:

**01/01/2009**

Ending:

**12/31/2009**

**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	\$ 21,804	\$ 3,913	\$ 2,181	\$ (1,732)	10 YRS	\$ 3,509	71
72	Current Year Purchases	52,128	31,277	2,606	(28,671)	10 YRS	2,606	72
73	Fully Depreciated Assets							73
74	<b>RELATED PARTY</b>		211	211				74
75	<b>TOTALS</b>	\$ 73,932	\$ 35,401	\$ 4,998	\$ (30,403)		\$ 6,115	75

**D. Vehicle Depreciation (See instructions.)\***

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	<b>TOTALS</b>			\$	\$	\$	\$		\$	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)	\$ 306,602	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 42,309	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 11,906	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (30,403)	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 19,007	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	<b>TOTALS</b>	\$	\$	\$	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.



**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><b>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?</b></p> <p><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><b>THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES</b></p>	<p><b>2. CLASSROOM PORTION:</b></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><b>3. CLINICAL PORTION:</b></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			
		1	2	3	4
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	<b>TOTALS</b>	\$	\$	\$	\$
10	<b>SUM OF line 9, col. 1 and 2 (e)</b>	\$			

**C. CONTRACTUAL INCOME**

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

\$

**D. NUMBER OF CNAs TRAINED**

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

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

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

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

	Service	1 Schedule V Line & Column Reference	2 Staff		4 Outside Practitioner (other than consultant)		6 Supplies (Actual or Allocated)	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39-3	hrs	\$		\$ 7,040	\$		\$ 7,040	1
2	Licensed Speech and Language Development Therapist	39-3	hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			46,069			46,069	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				142,613		142,613	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): <u>lab</u>	39-2					4,163		4,163	13
14	<b>TOTAL</b>			\$		\$ 53,109	\$ 146,776		\$ 199,885	14

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

Facility Name & ID Number **SOUTHVIEW MANOR**# **0048421**Report Period Beginning: **01/01/2009**

Ending:

**12/31/2009****XV. BALANCE SHEET - Unrestricted Operating Fund.**As of **12/31/2009**

(last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 19,441	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance (260,000) )	2,191,467		3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	139,106		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): R.E & INS ESCROW	138,258		9
10	<b>TOTAL Current Assets</b> (sum of lines 1 thru 9)	\$ 2,488,272	\$	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	186,651		15
16	Equipment, at Historical Cost	73,932		16
17	Accumulated Depreciation (book methods)	(60,102)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	131,475		21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	<b>TOTAL Long-Term Assets</b> (sum of lines 11 thru 23)	\$ 331,956	\$	24
25	<b>TOTAL ASSETS</b> (sum of lines 10 and 24)	\$ 2,820,228	\$	25

		1 Operating	2 After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 299,914	\$	26
27	Officer's Accounts Payable	13,000		27
28	Accounts Payable-Patient Deposits	1,268		28
29	Short-Term Notes Payable	1,345,216		29
30	Accrued Salaries Payable	56,075		30
31	Accrued Taxes Payable (excluding real estate taxes)	14,117		31
32	Accrued Real Estate Taxes(Sch.IX-B)	245,665		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36				36
37				37
38	<b>TOTAL Current Liabilities</b> (sum of lines 26 thru 37)	\$ 1,975,255	\$	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43				43
44				44
45	<b>TOTAL Long-Term Liabilities</b> (sum of lines 39 thru 44)	\$	\$	45
46	<b>TOTAL LIABILITIES</b> (sum of lines 38 and 45)	\$ 1,975,255	\$	46
47	<b>TOTAL EQUITY</b> (page 18, line 24)	\$ 844,973	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY</b> (sum of lines 46 and 47)	\$ 2,820,228	\$	48

\*(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>907,187</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>	<b>ROUNDING</b>	<b>2</b>	<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>907,189</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>27,811</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>(424,495)</b>	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe) <b>CONTRIBUTED CAPITAL</b>	<b>334,468</b>	<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>(62,216)</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>844,973</b>	<b>24</b> *

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

Facility Name &amp; ID Number SOUTHVIEW MANOR

# 0048421

Report Period Beginning: 01/01/2009

Ending:

12/31/2009

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

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

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

		1	
Revenue		Amount	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 8,369,686	1
2	Discounts and Allowances for all Levels	( )	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 8,369,686	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,593	6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 2,593	8
<b>C. Other Operating Revenue</b>			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	43,311	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 43,311	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<b>PRIOR YEAR ADJUSTMENT</b>	12,100	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 12,100	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 8,427,690	30

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	1,683,201	31
32	Health Care	2,713,108	32
33	General Administration	1,662,336	33
<b>B. Capital Expense</b>			
34	Ownership	2,031,849	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	199,885	35
36	Provider Participation Fee	109,500	36
<b>D. Other Expenses (specify):</b>			
37	<b>OUT-OF-PERIOD EXPENSES</b>		37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 8,399,879	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	27,811	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 27,811	43

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

\*\* Does this agree with taxable income (loss) per Federal Income Tax Return? NO If not, please attach a reconciliation.  
TAX RETURN PREPARED ON CASH BASIS

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

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

Facility Name & ID Number SOUTHVIEW MANOR

# 0048421

Report Period Beginning:

01/01/2009

Ending:

12/31/2009

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

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	2,264	2,407	\$ 83,026	\$ 34.49	1
2	Assistant Director of Nursing	1,742	1,823	54,692	30.00	2
3	Registered Nurses	1,594	1,742	48,942	28.10	3
4	Licensed Practical Nurses	42,580	46,297	1,046,275	22.60	4
5	CNAs & Orderlies	77,990	82,705	745,852	9.02	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,845	1,965	20,809	10.59	8
9	Activity Director					9
10	Activity Assistants	10,864	11,610	111,993	9.65	10
11	Social Service Workers	17,706	18,380	319,658	17.39	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	22,871	24,871	246,873	9.93	15
16	Dishwashers					16
17	Maintenance Workers	7,308	7,893	113,051	14.32	17
18	Housekeepers	34,988	37,781	356,416	9.43	18
19	Laundry	5,585	6,056	54,320	8.97	19
20	Administrator	2,078	2,110	106,897	50.66	20
21	Assistant Administrator	40	40	1,714	42.85	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	20,725	22,092	259,779	11.76	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	2,051	2,184	31,737	14.53	31
32	Other Health C: MDS, QA	4,867	5,096	123,291	24.19	32
33	Other(specify) SECURITY	20,932	21,815	182,402	8.36	33
34	TOTAL (lines 1 - 33)	278,030	296,867	\$ 3,907,727 *	\$ 13.16	34

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

\*\* See instructions.

B. CONSULTANT SERVICES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference		
35	Dietary Consultant	M	\$ 10,091	1-3	35
36	Medical Director	O	2,400	9-3	36
37	Medical Records Consultant	N	0	10-3	37
38	Nurse Consultant	T	0	10-3	38
39	Pharmacist Consultant	H	9,600	10-3	39
40	Physical Therapy Consultant	L	760	10a-3	40
41	Occupational Therapy Consultant	Y	0	10a-3	41
42	Respiratory Therapy Consultant		31,500	10a-3	42
43	Speech Therapy Consultant	F	0	10a-3	43
44	Activity Consultant	E	3,064	11-3	44
45	Social Service Consultant	E	2,075	12-3	45
46	Other(specify) DENTAL	S	4,800	10-3	46
47	Psychiatric Consultant		4,800	10-3	47
48					48
49	TOTAL (lines 35 - 48)		\$ 69,090		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				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)		\$		53



Facility Name & ID Number **SOUTHVIEW MANOR**

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

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

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

**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? YES
- (2) Are there any dues to nursing home associations included on the cost report? YES  
If YES, give association name and amount. IL COUNCIL LONG TERM CARE \$9,076
- (3) Did the nursing home make political contributions or payments to a political action organization? YES If YES, have these costs been properly adjusted out of the cost report? YES
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity? \_\_\_\_\_
- (5) Have you properly capitalized all major repairs and equipment purchases? YES  
What was the average life used for new equipment added during this period? 10 YR
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 0 Line 10-2
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? NO  
If YES, give effective date of lease. \_\_\_\_\_
- (9) Are you presently operating under a sublease agreement? \_\_\_\_\_ YES \_\_\_\_\_ NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES X NO \_\_\_\_\_ If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.  
SOUTHVIEW MANOR INC #0038943 11/01/06
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 109,500  
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? NO If YES, attach an explanation of the allocation.

- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? YES
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? NO For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? N/A Indicate the amount. \$ \_\_\_\_\_
- (16) Travel and Transportation
  - a. Are there costs included for out-of-state travel? NO  
If YES, attach a complete explanation.
  - b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such a program during this reporting period. \$ \_\_\_\_\_
  - c. What percent of all travel expense relates to transportation of nurses and patients? 5%
  - d. Have vehicle usage logs been maintained? NO
  - e. Are all vehicles stored at the nursing home during the night and all other times when not in use? NO
  - f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? YES
  - g. Does the facility transport residents to and from day training? NO**  
**Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A**
- (17) Has an audit been performed by an independent certified public accounting firm? NO  
Firm Name: \_\_\_\_\_
- (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.