

		FOR BHF USE					

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**2010**  
**STATE OF ILLINOIS**  
**DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES**  
**FINANCIAL AND STATISTICAL REPORT (COST REPORT)**  
**FOR LONG-TERM CARE FACILITIES**  
**(FISCAL YEAR 2010)**

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.

<p><b>I. IDPH License ID Number:</b> <u>0039669</u></p> <p><b>Facility Name:</b> <u>Lake Cook Terrace Nursing Ctr</u></p> <p><b>Address:</b> <u>263 Skokie Boulevard</u> <u>Northbrook</u> <u>60062</u>        Number City Zip Code</p> <p><b>County:</b> <u>Cook</u></p> <p><b>Telephone Number:</b> <u>(847) 564-0505</u> Fax # <u>(847) 564-3775</u></p> <p><b>HFS ID Number:</b> _____</p> <p><b>Date of Initial License for Current Owners:</b> <u>09/28/1981</u></p> <p><b>Type of Ownership:</b></p> <table style="width:100%"> <tr> <td><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input checked="" type="checkbox"/> PROPRIETARY</td> <td><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td><b>IRS Exemption Code</b> _____</td> <td><input type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input checked="" type="checkbox"/> "Sub-S" Corp.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Limited Liability Co.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other _____</td> <td></td> </tr> </table> <p><b>In the event there are further questions about this report, please contact:</b>  <b>Name:</b> <u>Steve Lavenda</u> <b>Telephone Number:</b> <u>(847) 236-1111</u>  <b>Email Address:</b> _____</p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County	<b>IRS Exemption Code</b> _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input checked="" type="checkbox"/> "Sub-S" Corp.			<input type="checkbox"/> Limited Liability Co.			<input type="checkbox"/> Trust			<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>01/01/10</u> to <u>12/31/10</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%"> <tr> <td style="width:20%; vertical-align: top;"> <b>Officer or Administrator of Provider</b> </td> <td>         (Signed) _____          (Type or Print Name) _____          (Title) _____       </td> </tr> <tr> <td style="vertical-align: top;"> <b>Paid Preparer</b> </td> <td>         (Signed) _____          (Date) _____          (Print Name and Title) <u>Garry S. Chankin, C.P.A.</u>          (Firm Name &amp; Address) <u>Frost, Ruttenberg &amp; Rothblatt, P.C.</u>  <u>111 Pfingsten Road, Suite 300 Deerfield, IL 60015</u>          (Telephone) <u>(847) 236-1111</u> Fax # <u>(847) 236-1155</u> </td> </tr> </table> <p align="right">MAIL TO: BUREAU OF HEALTH FINANCE        ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES        201 S. Grand Avenue East        Springfield, IL 62763-0001 Phone # (217) 782-1630</p>	<b>Officer or Administrator of Provider</b>	(Signed) _____ (Type or Print Name) _____ (Title) _____	<b>Paid Preparer</b>	(Signed) _____ (Date) _____ (Print Name and Title) <u>Garry S. Chankin, C.P.A.</u> (Firm Name & Address) <u>Frost, Ruttenberg &amp; Rothblatt, P.C.</u> <u>111 Pfingsten Road, Suite 300 Deerfield, IL 60015</u> (Telephone) <u>(847) 236-1111</u> Fax # <u>(847) 236-1155</u>
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SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lake Cook Terrace Nursing Ctr

# 0039669 Report Period Beginning: 01/01/10 Ending: 12/31/10

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	86	Skilled (SNF)	86	31,390	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	134	TOTALS	134	48,910	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment				5 Total	
		3 Medicaid Recipient	4 Private Pay	Other	Total		
8	SNF	3,329	1,155	3,531	8,015	8	
9	SNF/PED					9	
10	ICF	34,491	1,942	781	37,214	10	
11	ICF/DD					11	
12	SC					12	
13	DD 16 OR LESS					13	
14	TOTALS	37,820	3,097	4,312	45,229	14	

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 92.47%

D. How many bed-hold days during this year were paid by the Department? None (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)  
None

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

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?  
YES  NO

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?  
YES  NO

I. On what date did you start providing long term care at this location?  
Date started 08/01/1993

J. Was the facility purchased or leased after January 1, 1978?  
YES  Date 08/01/1993 NO

K. Was the facility certified for Medicare during the reporting year?  
YES  NO  If YES, enter number of beds certified 83 and days of care provided 3,255

Medicare Intermediary Naitonal Government Services

IV. ACCOUNTING BASIS

ACCRAUAL  MODIFIED CASH\*  CASH\*

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

Tax Year: 12/31/10 Fiscal Year: 12/31/10

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

Facility Name & ID Number Lake Cook Terrace Nursing Ctr # 0039669 Report Period Beginning: 01/01/10 Ending: 12/31/10

**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	264,337	35,843	5,673	305,853		305,853		305,853		1
2	Food Purchase		248,562		248,562	(29,383)	219,180	(170)	219,010		2
3	Housekeeping	217,086	39,215		256,301		256,301		256,301		3
4	Laundry	74,190	8,208	10,145	92,543		92,543		92,543		4
5	Heat and Other Utilities			115,015	115,015		115,015	1,024	116,039		5
6	Maintenance	121,767	37,923	112,150	271,840		271,840	20,407	292,247		6
7	Other (specify):*										7
8	<b>TOTAL General Services</b>	677,380	369,751	242,983	1,290,114	(29,383)	1,260,732	21,261	1,281,993		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			3,900	3,900		3,900		3,900		9
10	Nursing and Medical Records	2,180,126	183,970	7,255	2,371,351		2,371,351	(17,776)	2,353,575		10
10a	Therapy	137,217	765		137,982		137,982		137,982		10a
11	Activities	49,402	24,043		73,445		73,445		73,445		11
12	Social Services	247,783		5,875	253,658		253,658		253,658		12
13	CNA Training										13
14	Program Transportation			7,678	7,678		7,678		7,678		14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	2,614,528	208,778	24,708	2,848,014		2,848,014	(17,776)	2,830,238		16
	<b>C. General Administration</b>										
17	Administrative	185,749		393,175	578,924		578,924	(254,207)	324,717		17
18	Directors Fees										18
19	Professional Services			39,621	39,621		39,621		39,621		19
20	Dues, Fees, Subscriptions & Promotions			21,336	21,336		21,336	(11,307)	10,029		20
21	Clerical & General Office Expenses	36,055	2,570	132,036	170,661		170,661	(74,413)	96,248		21
22	Employee Benefits & Payroll Taxes			551,388	551,388	29,383	580,771		580,771		22
23	Inservice Training & Education										23
24	Travel and Seminar			1,823	1,823		1,823		1,823		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			115,822	115,822		115,822	107	115,929		26
27	Other (specify):*							11,402	11,402		27
28	<b>TOTAL General Administration</b>	221,804	2,570	1,255,201	1,479,575	29,383	1,508,958	(328,417)	1,180,540		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	3,513,712	581,099	1,522,892	5,617,703		5,617,703	(324,933)	5,292,770		29

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name &amp; ID Number

Lake Cook Terrace Nursing Ctr

#0039669

Report Period Beginning:

01/01/10

Ending:

12/31/10

## 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			142,003	142,003		142,003	158,743	300,746			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			116	116		116	204,521	204,637			32
33	Real Estate Taxes							203,264	203,264			33
34	Rent-Facility & Grounds			482,488	482,488		482,488	(472,062)	10,426			34
35	Rent-Equipment & Vehicles			6,970	6,970		6,970		6,970			35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			631,577	631,577		631,577	94,466	726,043			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		221,926	243,196	465,122		465,122		465,122			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			73,365	73,365		73,365		73,365			42
43	Other (specify):*			2,761	2,761		2,761	(2,761)	(0)			43
44	<b>TOTAL Special Cost Centers</b>		221,926	319,322	541,248		541,248	(2,761)	538,487			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	3,513,712	803,025	2,473,791	6,790,528		6,790,528	(233,228)	6,557,300			45

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

SEE ACCOUNTANTS' COMPILATION REPORT

**VI. ADJUSTMENT DETAIL**

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

		1	2	3	
	<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	(618)	06		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	95,490	30		9
10	Interest and Other Investment Income	(21,523)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(170)	02		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	(160)	21		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	(65,029)	21		24
25	Fund Raising, Advertising and Promotional	(3,575)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(254)	21		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(96,598)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (92,437)		\$	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	
		<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)	(140,791)		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ (140,791)		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ (233,228)		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.			\$	38
39					39
40	Gift and Coffee Shops				40
41	Barber and Beauty Shops				41
42	Laboratory and Radiology				42
43	Prescription Drugs				43
44					44
45	Other-Attach Schedule				45
46	Other-Attach Schedule				46
47	<b>TOTAL (C): (sum of lines 38-46)</b>			\$	47

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

SEE ACCOUNTANTS' COMPILATION REPORT

Lake Cook Terrace Nursing Ctr

ID# 0039669

Report Period Beginning: 01/01/10

Ending: 12/31/10

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Marketing	\$ (2,761)	43	1
2	Telephone Advertising	(4,584)	20	2
3	Bank Charges	(1,004)	21	3
4	COPE Dues	(3,148)	20	4
5	Veterans Pharmacy Expense	(14,520)	10	5
6	Veterans Lab Expense	(764)	10	6
7	Veterans Physician Visits	(2,492)	10	7
8	Miscellaneous Income	(7,966)	21	8
9	Bldg. Company Political Contributions	(3,000)	20	9
10	Bldg. Company License & Fees	(350)	20	10
11	Bldg. Company Step-up Basis Depreciation	(71,737)	30	11
12	Building Company Amortization	(1,780)	36	12
13	Additional R&M	19,299	06	13
14	Building Company Accounting Fees	(1,791)	19	14
15				15
16				16
17				17
18				18
19				19
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41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	<b>Total</b>	(96,598)		49

Lake Cook Terrace Nursing Ctr

ID# 0039669

Report Period Beginning: 01/01/10

Ending: 12/31/10

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
50		\$	1
51			2
52			3
53			4
54			5
55			6
56			7
57			8
58			9
59			10
60			11
61			12
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## STATE OF ILLINOIS

Summary A

Facility Name & ID Number Lake Cook Terrace Nursing Ctr# 0039669

Report Period Beginning:

01/01/10

Ending:

12/31/10

## 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													1
2	Food Purchase	(170)											(170)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities				1,024								1,024	5
6	Maintenance	18,681			1,726								20,407	6
7	Other (specify):*													7
8	<b>TOTAL General Services</b>	<b>18,511</b>			<b>2,750</b>								<b>21,261</b>	<b>8</b>
	<b>B. Health Care and Programs</b>													
9	Medical Director													9
10	Nursing and Medical Records	(17,776)											(17,776)	10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*													15
16	<b>TOTAL Health Care and Programs</b>	<b>(17,776)</b>											<b>(17,776)</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative			4,636	(336,835)	77,992							(254,207)	17
18	Directors Fees													18
19	Professional Services	(1,791)	1,791											19
20	Fees, Subscriptions & Promotions	(14,657)	3,350										(11,307)	20
21	Clerical & General Office Expenses	(74,413)											(74,413)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar													24
25	Other Admin. Staff Transportation													25
26	Insurance-Prop.Liab.Malpractice				107								107	26
27	Other (specify):*			4,931	64	6,407							11,402	27
28	<b>TOTAL General Administration</b>	<b>(90,860)</b>	<b>5,141</b>	<b>9,567</b>	<b>(336,664)</b>	<b>84,399</b>							<b>(328,417)</b>	<b>28</b>
29	<b>TOTAL Operating Expense</b> <b>(sum of lines 8,16 &amp; 28)</b>	<b>(90,126)</b>	<b>5,141</b>	<b>9,567</b>	<b>(333,914)</b>	<b>84,399</b>							<b>(324,933)</b>	<b>29</b>

## STATE OF ILLINOIS

Summary B

Facility Name & ID Number Lake Cook Terrace Nursing Ctr# 0039669

Report Period Beginning:

01/01/10

Ending:

12/31/10

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	<b>D. Ownership</b>													
30	Depreciation	23,753	134,990										158,743	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(21,523)	226,044										204,521	32
33	Real Estate Taxes		199,735		3,529								203,264	33
34	Rent-Facility & Grounds		(478,207)		6,145								(472,062)	34
35	Rent-Equipment & Vehicles													35
36	Other (specify):*	(1,780)	1,780											36
37	<b>TOTAL Ownership</b>	<b>450</b>	<b>84,342</b>		<b>9,674</b>								<b>94,466</b>	<b>37</b>
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers													39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(2,761)											(2,761)	43
44	<b>TOTAL Special Cost Centers</b>	<b>(2,761)</b>											<b>(2,761)</b>	<b>44</b>
	<b>GRAND TOTAL COST</b>													
45	<b>(sum of lines 29, 37 &amp; 44)</b>	<b>(92,437)</b>	<b>89,483</b>	<b>9,567</b>	<b>(324,240)</b>	<b>84,399</b>							<b>(233,228)</b>	<b>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		See Attached		See Attached		
				GAF Associates	Northbrook	Building Company

**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	34 Rent	\$ 478,207	GAF Associates	100.00%	\$	(478,207)	1	
2	V	32 Mortgage Interest Expense		GAF Associates		226,044	226,044	2	
3	V	36 Amortization Loan Fee		GAF Associates		1,280	1,280	3	
4	V	36 Amortization LF Buy Out		GAF Associates		500	500	4	
5	V	30 Depreciation Expense		GAF Associates		63,253	63,253	5	
6	V	30 Step-up Basis Depreciation		GAF Associates		71,737	71,737	6	
7	V	20 License & Permits		GAF Associates		350	350	7	
8	V	20 Political Contributions		GAF Associates		3,000	3,000	8	
9	V	33 Real Estate Tax		GAF Associates		199,735	199,735	9	
10	V	19 Accounting Fees		GAF Associates		1,791	1,791	10	
11	V							11	
12	V							12	
13	V							13	
14	Total		\$ 478,207			\$ 567,690	\$ *	89,483	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 SALARY - STAN ARON	\$	PRO HEALTH CARE, INC.	100.00%	\$ 60,976	\$ 60,976	15
16	V	27 PAYROLL TAXES				4,931	4,931	16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V	17 MNGMNT. FEES - PRO HEALTH	56,340				(56,340)	24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$ 56,340			\$ 65,907	\$ * 9,567	39

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	5 UTILITIES	\$	BARTON MANAGEMENT INC.	100.00%	\$ 1,024	\$ 1,024
16	V	6 REPAIRS AND MAINT.		BARTON MANAGEMENT INC.		1,726	1,726
17	V	26 INSURANCE		BARTON MANAGEMENT INC.		107	107
18	V	27 EMP. BEN. GEN. ADMIN		BARTON MANAGEMENT INC.		64	64
19	V	33 REAL ESTATE TAXES		BARTON MANAGEMENT INC.		3,529	3,529
20	V	34 RENT OFFICE SPACE		BARTON MANAGEMENT INC.		6,145	6,145
21	V						
22	V						
23	V	17 MANAGEMENT FEES	336,835				(336,835)
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 336,835			\$ 12,595	\$ * (324,240)

\* 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		\$	REDWOOD MANAGEMENT	100.00%	\$	\$	15
16	V							16
17	V							17
18	V							18
19	V	17 SALARY-J.SHLOFROCK				13,889	13,889	19
20	V	27 PAYROLL TAXES-JS				1,140	1,140	20
21	V							21
22	V	17 SALARY-S. ARON				64,103	64,103	22
23	V	27 PAYROLL TAXES-SA				5,267	5,267	23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	<b>Total</b>		\$			\$ 84,399	\$ * 84,399	39

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

**VII. RELATED PARTIES (continued)**

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	<b>Total</b>		\$			\$	\$ *	39

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

**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: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	<b>Total</b>		\$			\$	\$ *	39

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

**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: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	<b>Total</b>		\$			\$	\$ *	39

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

**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: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	<b>Total</b>		\$			\$	\$ *	39

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

**VII. RELATED PARTIES (continued)**

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	<b>Total</b>		\$			\$	\$ *	39

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

**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: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	<b>Total</b>		\$			\$	\$ *	39

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

Facility Name &amp; ID Number

Lake Cook Terrace Nursing Ctr

# 0039669

Report Period Beginning:

01/01/10

Ending:

12/31/10

## 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	Stan Aron		Administrative		See Attached	25	45.45%	Alloc. Salary	\$ 125,078	17-7	1
2	John Shlofrock	Owner	Administrative		See Attached	5	10.64%	Alloc. Salary	13,889	17-7	2
3	Rick Duros	Owner	Administrative		See Attached	5.5	11.00%				3
4	Gary Weintraub	Owner	Administrative		See Attached	4	9.76%				4
5	Elisa Slofrock - Zusman	Owner	Clerical		See Attached	5	11.90%				5
6											6
7											7
8											8
9	Where applicable, the amounts reported on this page have been adjusted from the actual costs to reflect only										9
10	amounts anticipated to be considered allowable by the Illinois Department of Health & Family Services.										10
11											11
12											12
13								TOTAL	\$ 138,967		13

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lake Cook Terrace Nursing Ctr

# 0039669

Report Period Beginning:

01/01/10

Ending: 12/31/10

**VIII. ALLOCATION OF INDIRECT COSTS**

Name of Related Organization \_\_\_\_\_

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

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

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

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

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	<b>TOTALS</b>				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lake Cook Terrace Nursing Ctr

# 0039669

Report Period Beginning:

01/01/10

Ending: 12/31/10

VIII. ALLOCATION OF INDIRECT COSTS

Name of Related Organization PRO HEALTH CARE, INC. C/O FR&R  
 Street Address 111 PFINGSTEN ROAD  
 City / State / Zip Code DEERFIELD, IL 60115  
 Phone Number ( 847)236-1111  
 Fax Number ( 847)236-1155

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	17	SALARY - STAN ARON	AVG. HOURS WORKED 41	4	\$ 100,000	\$ 100,000	25	\$ 60,976	1
2	27	PAYROLL TAXES	AVG. HOURS WORKED 41	4	8,087		25	4,931	2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 108,087	\$ 100,000		\$ 65,907	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lake Cook Terrace Nursing Ctr

# 0039669

Report Period Beginning:

01/01/10

Ending: 12/31/10

VIII. ALLOCATION OF INDIRECT COSTS

Name of Related Organization

BARTON MANAGEMENT INC.

Street Address

465 CENTRAL AVE.

City / State / Zip Code

NORTHFIELD, IL 60093

Phone Number

( 847) 441-8200

Fax Number

( 847) 441-0800

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	5	UTILITIES	AVAILABLE DAYS	562,164	9	\$ 11,770	\$ 48,910	\$ 1,024	1
2	6	REPAIRS AND MAINT.	AVAILABLE DAYS	562,164	9	19,835	48,910	1,726	2
3	26	INSURANCE	AVAILABLE DAYS	562,164	9	1,231	48,910	107	3
4	27	EMP. BEN. GEN. ADMIN	AVAILABLE DAYS	562,164	9	739	48,910	64	4
5	33	REAL ESTATE TAXES	AVAILABLE DAYS	562,164	9	40,562	48,910	3,529	5
6	34	RENT OFFICE SPACE	AVAILABLE DAYS	562,164	9	70,633	48,910	6,145	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					\$ 144,770	\$	\$ 12,595	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lake Cook Terrace Nursing Ctr

# 0039669

Report Period Beginning:

01/01/10

Ending: 12/31/10

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 REDWOOD MANAGEMENT  
 Street Address 465 CENTRAL AVE. ,SUITE 100  
 City / State / Zip Code NORTHFIELD, IL. 60093  
 Phone Number (847) 441-8200  
 Fax Number (847) 441-0800

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1					\$	\$		\$	1	
2									2	
3									3	
4									4	
5	17	SALARY-J.SHLOFROCK	AVG HOURS WORKED	36	6	100,000	100,000	5	13,889	5
6	27	PAYROLL TAXES-JS	AVG HOURS WORKED	36	6	8,211		5	1,140	6
7									7	
8	17	SALARY-S. ARON	AVG HOURS WORKED	39	5	100,000	100,000	25	64,103	8
9	27	PAYROLL TAXES-SA	AVG HOURS WORKED	39	5	8,217		25	5,267	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					\$ 216,428	\$ 200,000	\$	84,399	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lake Cook Terrace Nursing Ctr

# 0039669

Report Period Beginning:

01/01/10

Ending: 12/31/10

**VIII. ALLOCATION OF INDIRECT COSTS**

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

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

Name of Related Organization \_\_\_\_\_

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

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

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	<b>TOTALS</b>				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lake Cook Terrace Nursing Ctr

# 0039669

Report Period Beginning:

01/01/10

Ending: 12/31/10

**VIII. ALLOCATION OF INDIRECT COSTS**

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

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

Name of Related Organization \_\_\_\_\_

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

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

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	<b>TOTALS</b>				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lake Cook Terrace Nursing Ctr

# 0039669

Report Period Beginning:

01/01/10

Ending: 12/31/10

**VIII. ALLOCATION OF INDIRECT COSTS**

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

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

Name of Related Organization \_\_\_\_\_

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

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

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	<b>TOTALS</b>				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lake Cook Terrace Nursing Ctr

# 0039669

Report Period Beginning:

01/01/10

Ending: 12/31/10

**VIII. ALLOCATION OF INDIRECT COSTS**

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

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

Name of Related Organization \_\_\_\_\_

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

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

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	<b>TOTALS</b>				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lake Cook Terrace Nursing Ctr

# 0039669

Report Period Beginning:

01/01/10

Ending: 12/31/10

**VIII. ALLOCATION OF INDIRECT COSTS**

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

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

Name of Related Organization \_\_\_\_\_

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

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

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	<b>TOTALS</b>				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lake Cook Terrace Nursing Ctr

# 0039669

Report Period Beginning:

01/01/10

Ending: 12/31/10

**VIII. ALLOCATION OF INDIRECT COSTS**

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

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

Name of Related Organization \_\_\_\_\_

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

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

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	<b>TOTALS</b>				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name &amp; ID Number

Lake Cook Terrace Nursing Ctr

# 0039669

Report Period Beginning:

01/01/10

Ending:

12/31/10

## 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												
												Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
													YES	NO				Original	Balance			
	<b>A. Directly Facility Related</b>																					
	<b>Long-Term</b>																					
1	MB Financial Bank		X	Mortgage		2009	\$	\$ 2,713,826			\$ 226,044	1										
2	Due to G.A.F. LTD	X						164				2										
3												3										
4												4										
5	See Supplemental Schedule											5										
	<b>Working Capital</b>																					
6	MB Financial Bank		X	Line of Credit							116	6										
7												7										
8	See Supplemental Schedule											8										
9	TOTAL Facility Related						\$	\$ 2,713,990			\$ 226,160	9										
	<b>B. Non-Facility Related*</b>																					
10	Interest Income		X								(21,523)	10										
11												11										
12												12										
13	See Supplemental Schedule											13										
14	TOTAL Non-Facility Related						\$	\$			\$ (21,523)	14										
15	TOTALS (line 9+line14)						\$	\$ 2,713,990			\$ 204,638	15										

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number

Lake Cook Terrace Nursing Ctr

# 0039669

Report Period Beginning:

01/01/10

Ending:

12/31/10

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

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







Facility Name & ID Number Lake Cook Terrace Nursing Ctr

# 0039669

Report Period Beginning:

01/01/10

Ending:

12/31/10

**X. BUILDING AND GENERAL INFORMATION:**

A. Square Feet: \_\_\_\_\_ B. General Construction Type: Exterior Brick Frame Brick 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:**

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1	<u>Facility</u>			\$ <u>200,000</u>	<u>1</u>
2					<u>2</u>
3	<b>TOTALS</b>			\$ <b>200,000</b>	<b>3</b>

SEE ACCOUNTANTS' COMPILATION REPORT

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										8
Improvement Type**										
9	Various		1994	61,594		20	3,080	3,080	50,024	9
10	Various		1995	220,229		20	11,011	11,011	171,064	10
11	Various		1996	141,678		20	7,084	7,084	103,706	11
12	Various		1997	117,480		20	5,874	5,874	80,432	12
13	Various		1998	60,311		20	3,016	3,016	38,885	13
14	Various		1999	91,031		20	4,270	4,270	51,945	14
15	Various		2000	217,093		20	5,962	5,962	63,804	15
16	Various		2001	104,774		20	5,239	5,239	48,763	16
17	Various		2002	144,415		20	8,666	8,666	84,089	17
18	Various		2003	111,222		20	6,420	6,420	62,236	18
19	Various		2004	79,149		20	4,780	4,780	31,990	19
20	Various		2005	50,187		20	3,576	3,576	22,008	20
21	Various		2006	103,057		20	6,095	6,095	27,176	21
22										22
23										23
24										24
25										25
26										26
27										27
28										28
29										29
30										30
31										31
32										32
33										33
34										34
35										35
36										36

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

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

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67		2,741,542	63,253		121,262	58,009	2,108,462	67
68								68
69			142,003			(142,003)		69
70		\$ 4,243,762	\$ 205,256		\$ 196,335	\$ (8,921)	\$ 2,944,585	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name &amp; ID Number Lake Cook Terrace Nursing Ctr

# 0039669

Report Period Beginning:

01/01/10

Ending:

12/31/10

## XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	<b>Totals from Page 12A, Carried Forward</b>		\$ 4,243,762	\$ 205,256		\$ 196,335	\$ (8,921)	\$ 2,944,585	1
2	Electrical & Lighting	2007	5,048		20	337	337	1,178	2
3	Water Heater	2007	1,014		20	85	85	338	3
4	Cooling Unit	2007	864		20	58	58	202	4
5	Domestic Water	2007	2,838		20	189	189	662	5
6	Carpeting	2007	5,445		20	778	778	2,787	6
7	Steel Frame	2007	4,200		20	280	280	980	7
8	Light Fixtures	2007	14,590		20	973	973	3,405	8
9	Cooler/Freezer Doors	2007	12,630		20	1,804	1,804	6,165	9
10	Water Pipe	2007	3,050		20	203	203	712	10
11	Compressor And Fan	2007	3,401		20	227	227	794	11
12	Fire Wood Door	2007	3,500		20	175	175	583	12
13	Fire Wood Door	2007	3,500		20	175	175	583	13
14	Steel Frame And Wood Door	2007	1,775		20	89	89	296	14
15	Steel Frame	2007	585		20	29	29	98	15
16	Boiler Repairs	2007	1,710		20	142	142	451	16
17	Control Unit	2007	1,522		20	102	102	355	17
18	Boiler Repairs	2007	1,074		20	90	90	284	18
19	Boiler Repairs	2007	1,212		20	101	101	311	19
20	Cubicle Curtains	2007	5,369		20	268	268	850	20
21	Boiler	2008	20,744		20	1,729	1,729	4,610	21
22	Boiler	2008	16,250		20	1,354	1,354	3,837	22
23	Water Heater	2008	1,680		20	140	140	385	23
24	Northwet Town	2008	1,631		20	82	82	224	24
25	Roofmedic	2008	1,857		20	93	93	255	25
26	Keypad	2008	1,467		20	73	73	196	26
27	Cove Bases, End Caps, Divider Bars	2008	7,057		20	353	353	912	27
28	Chiller	2008	17,778		20	3,556	3,556	9,185	28
29	Chiller	2008	2,350		20	470	470	1,214	29
30	Fence	2008	9,440		20	629	629	1,678	30
31	Parking Lot	2008	21,000		20	2,100	2,100	5,425	31
32	Security Cameras	2008	7,269		20	363	363	939	32
33	Chiller	2008	1,436		20	287	287	718	33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 4,427,048	\$ 205,256		\$ 213,669	\$ 8,413	\$ 2,995,198	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name &amp; ID Number Lake Cook Terrace Nursing Ctr

# 0039669

Report Period Beginning:

01/01/10

Ending:

12/31/10

## XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	<b>Totals from Page 12B, Carried Forward</b>		\$ 4,427,048	\$ 205,256		\$ 213,669	\$ 8,413	\$ 2,995,198	1
2	Water Tower	2008	1,231		20	103	103	256	2
3	Chiller	2008	3,525		20	705	705	1,763	3
4	Boiler	2008	2,296		20	191	191	478	4
5	Window Treatments	2008	17,616		20	1,762	1,762	4,257	5
6	Wallpaper	2008	7,110		20	1,422	1,422	3,436	6
7	Wiring	2008	2,088		20	104	104	244	7
8	Wandergard Door	2008	952		20	136	136	340	8
9	Overbed Lights	2008	4,415		20	883	883	2,060	9
10	Replacement Of Pump Assembly On Pump #5	2008	1,096		20	219	219	658	10
11	Replacement Of Valves And Parts On Boilers #5 And #6	2008	1,121		20	224	224	672	11
12	Pump-Kitchen	2008	1,484		20	297	297	816	12
13	Sewage Pump	2008	3,733		20	747	747	1,618	13
14	Pump	2008	1,225		20	245	245	551	14
15	Fan Replacement	2008	2,762		20	552	552	1,243	15
16	Water Valve Fix	2009	5,129		20	256	256	492	16
17	Catchbasin Replace - Parking Lot	2009	4,500		20	300	300	550	17
18	Expansion Tank	2009	3,672		20	184	184	337	18
19	Material For Pipe Repair	2009	3,000		20	600	600	1,000	19
20	Material For Pipe Repair	2009	12,540		20	2,508	2,508	3,553	20
21	Masonry And Tuck Point On Walls	2009	22,500		20	1,125	1,125	1,594	21
22	Install Smoke/Fire Dampers In Oxygen Room	2009	4,875		20	244	244	305	22
23	Replace Awning	2009	3,540		20	177	177	221	23
24	Wallpaper	2009	7,162		20	716	716	895	24
25	Fire Alarm System	2009	31,276		20	1,564	1,564	1,824	25
26	Sprinkler System	2009	141,000		20	7,050	7,050	8,225	26
27	Mattress	2009	3,659		20	732	732	854	27
28	Wallpaper	2010	6,747		20	618	618	618	28
29	Drapery And Rods	2010	3,139		20	288	288	288	29
30	Whirlpool Bath	2010	18,737		20	3,435	3,435	3,435	30
31	Repair Roof	2010	9,575		20	399	399	399	31
32	Water Heater Pipe Repair	2010	4,020		20	134	134	134	32
33	Wanderguard Control Unit	2010	2,605		20	478	478	478	33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 4,765,377	\$ 205,256		\$ 242,066	\$ 36,810	\$ 3,038,792	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

**XI. OWNERSHIP COSTS (continued)**

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	<b>Totals from Page 12C, Carried Forward</b>		\$ 4,765,377	\$ 205,256		\$ 242,066	\$ 36,810	\$ 3,038,792	1
2	Chair Rail	2010	2,844		20	190	190	190	2
3	Flooring & Chair Rail	2010	9,680		20	242	242	242	3
4	Flooring Material	2010	2,600		20	87	87	87	4
5	Flooring, Paint, Electrical Materials	2010	8,406		20	280	280	280	5
6	Chair Rail	2010	2,922		20	66	66	66	6
7	Ventilation Air In Rooms	2010	22,235		20	185	185	185	7
8	Replace Main Floor Exhaust Fans	2010	20,882		20	87	87	87	8
9	Replace Main Floor Exhaust Fans	2010	16,255		20	68	68	68	9
10	Spinkler System	2010	28,802		20	720	720	720	10
11	Hvac Cross Tees, Ceiling Tile	2010	3,934		20	33	33	33	11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 4,883,938	\$ 205,256		\$ 244,024	\$ 38,768	\$ 3,040,750	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 4,883,938	\$ 205,256		\$ 244,024	\$ 38,768	\$ 3,040,750	1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34	TOTAL (lines 1 thru 33)	\$ 4,883,938	\$ 205,256		\$ 244,024	\$ 38,768	\$ 3,040,750	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	<b>Building Company Information</b>								1
2	<b>Buildings:</b>								2
3	G.A.F. Partnership - 134 Bed Facility	1976	2,132,500		20	106,625	106,625	1,521,454	3
4	G.A.F. Partnership - 134 Bed Facility	1976	25,000		20	1,250	1,250	18,750	4
5									5
6	G.A.F. Associates Depreciation Expense			63,253			(63,253)		6
7									7
8	<b>Leasehold Improvements:</b>								8
9									9
10	G.A.F. Parntership	1981	5,694		20			5,694	10
11	G.A.F. Parntership	1982	17,924		20			17,924	11
12	G.A.F. Parntership	1983	5,201		20			5,201	12
13	G.A.F. Parntership	1984	27,884		20			27,884	13
14	G.A.F. Parntership	1985	77,350		20			77,350	14
15	G.A.F. Parntership	1986	37,603		20			37,603	15
16	G.A.F. Parntership	1987	38,247		20			38,247	16
17	G.A.F. Parntership	1988	13,918		20			13,918	17
18	G.A.F. Parntership	1989	53,326		20			53,326	18
19	G.A.F. Parntership	1990	39,155		20			39,155	19
20	G.A.F. Parntership	1991	101,697		20	5,085	5,085	101,697	20
21	G.A.F. Parntership	1992	16,406		20	820	820	15,586	21
22	G.A.F. Parntership	1993	149,637		20	7,482	7,482	134,673	22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34									34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
1		\$	\$		\$	\$	\$
2							
3							
4							
5							
6							
7							
8							
9							
10							
11							
12							
13							
14							
15							
16							
17							
18							
19							
20							
21							
22							
23							
24							
25							
26							
27							
28							
29							
30							
31							
32							
33							
34	TOTAL (12F & 12G lines 1 thru 33)	\$ 2,741,542	\$ 63,253		\$ 121,262	\$ 58,009	\$ 2,108,462

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Related Party Information		\$	\$		\$	\$	\$	1
2	Buildings:								2
3									3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								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

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Lake Cook Terrace Nursing Ctr

# 0039669

Report Period Beginning:

01/01/10

Ending:

12/31/10

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	\$ 465,011	\$	\$ 51,754	\$ 51,754	10	\$ 335,443	71
72	Current Year Purchases	29,127		2,792	2,792	10	2,792	72
73	Fully Depreciated Assets	644,780		37	37	10	644,780	73
74								74
75	TOTALS	\$ 1,138,919	\$	\$ 54,583	\$ 54,583		\$ 983,016	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		VAN-ANTHONY PONTIAC	2008	\$ 14,233	\$	\$ 2,140	\$ 2,140	5	\$ 6,388	76
77										77
78										78
79										79
80	TOTALS			\$ 14,233	\$	\$ 2,140	\$ 2,140		\$ 6,388	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)	\$ 6,237,090	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 205,256	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 300,746	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 95,490	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 4,030,154	85

\*\*

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

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

G. Construction-in-Progress

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

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

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

**XII. RENTAL COSTS**

**A. Building and Fixed Equipment (See instructions.)**

1. Name of Party Holding Lease: \_\_\_\_\_

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	Storage Unit Rental			4,284			5
6	Allocated from Barton Management			6,145			6
7	TOTAL			\$ 10,429			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? \_\_\_\_\_

16. Rental Amount for movable equipment: \$ 6,969 Description: See Attached Schedule  YES  NO

(Attach a schedule detailing the breakdown of movable equipment)

**C. Vehicle Rental (See instructions.)**

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

10. Effective dates of current rental agreement:

Beginning \_\_\_\_\_

Ending \_\_\_\_\_

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

Fiscal Year Ending Annual Rent

12. \_\_\_\_\_/2011 \$ \_\_\_\_\_

13. \_\_\_\_\_/2012 \$ \_\_\_\_\_

14. \_\_\_\_\_/2013 \$ \_\_\_\_\_

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

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

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

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

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. <u>CLASSROOM PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
--	---	--

**B. EXPENSES**

**ALLOCATION OF COSTS (d)**

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

**C. CONTRACTUAL INCOME**

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

\$

**D. NUMBER OF CNAs TRAINED**

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

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

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

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

	Service	1 Schedule V Line & Column Reference	2		3		4		5	6	7	8		
			Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)						Total Cost (Col. 3 + 5 + 6)
			Units of Service	Cost	Units	Cost								
1	Licensed Occupational Therapist	39 - 03	hrs	\$		\$	131,122	\$			\$	131,122	1	
2	Licensed Speech and Language Development Therapist	39 - 03	hrs				9,631					9,631	2	
3	Licensed Recreational Therapist		hrs										3	
4	Licensed Physical Therapist	39 - 03	hrs				102,443					102,443	4	
5	Physician Care		visits										5	
6	Dental Care		visits										6	
7	Work Related Program		hrs										7	
8	Habilitation		hrs										8	
9	Pharmacy	39 - 02	# of prescrpts						205,094			205,094	9	
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs										10	
11	Academic Education		hrs										11	
12	Other (specify): _____												12	
13	Other (specify): <u>See Supplemental</u>								16,832			16,832	13	
14	TOTAL			\$		\$	243,196	\$	221,926	\$		465,122	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 Lake Cook Terrace Nursing Ctr# 0039669Report Period Beginning: 01/01/10Ending: 12/31/10

## XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/10

(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	\$ 771,429	\$ 812,137	1
2	Cash-Patient Deposits	46,380	46,380	2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance )	408,246	408,246	3
4	Supply Inventory (priced at )			4
5	Short-Term Investments	2,000	2,000	5
6	Prepaid Insurance	70,049	70,049	6
7	Other Prepaid Expenses	1,588	1,588	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>See Attached Schedule</u>	126,854	206,200	9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 1,426,546	\$ 1,546,600	10
<b>B. Long-Term Assets</b>				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		6,260,318	13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	1,968,315	1,968,315	15
16	Equipment, at Historical Cost	866,176	866,176	16
17	Accumulated Depreciation (book methods)	(1,475,310)	(3,286,906)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <u>See Attached Schedule</u>			23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 1,359,181	\$ 5,807,903	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 2,785,727	\$ 7,354,503	25

		1 Operating	2 After Consolidation*	
<b>C. Current Liabilities</b>				
26	Accounts Payable	\$ 218,515	\$ 218,514	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	53,986	53,986	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	139,095	139,095	30
31	Accrued Taxes Payable (excluding real estate taxes)	10,404	10,404	31
32	Accrued Real Estate Taxes(Sch.IX-B)		183,980	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
<b>Other Current Liabilities(specify):</b>				
36	<u>See Attached Schedule</u>	657,486	657,486	36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 1,079,486	\$ 1,263,465	38
<b>D. Long-Term Liabilities</b>				
39	Long-Term Notes Payable		164	39
40	Mortgage Payable		2,713,826	40
41	Bonds Payable			41
42	Deferred Compensation			42
<b>Other Long-Term Liabilities(specify):</b>				
43	<u>See Attached Schedule</u>			43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$	\$ 2,713,990	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 1,079,486	\$ 3,977,455	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 1,706,241	\$ 3,377,048	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 2,785,727	\$ 7,354,503	48

SEE ACCOUNTANTS' COMPILATION REPORT

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		1 Total	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>2,221,649</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>	<b>Treasury Stock</b>	(605,533)	<b>3</b>
<b>4</b>	<b>Depreciation &amp; Real Estate Entries</b>	(137,121)	<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>1,478,995</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	327,246	<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	(100,000)	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ <b>227,246</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>1,706,241</b>	<b>24</b> *

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lake Cook Terrace Nursing Ctr# 0039669Report Period Beginning: 01/01/10Ending: 12/31/10

**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	\$ 6,671,593	1
2	Discounts and Allowances for all Levels	(330,783)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	<b>\$ 6,340,810</b>	<b>3</b>
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	548,883	6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	<b>\$ 548,883</b>	<b>8</b>
<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	173,360	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	12,625	19
20	Radiology and X-Ray	4,210	20
21	Other Medical Services	8,143	21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	<b>\$ 198,338</b>	<b>23</b>
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	21,523	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	<b>\$ 21,523</b>	<b>26</b>
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<u>See Supplemental Schedule</u>	8,220	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	<b>\$ 8,220</b>	<b>29</b>
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	<b>\$ 7,117,774</b>	<b>30</b>

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	1,290,114	31
32	Health Care	2,848,014	32
33	General Administration	1,479,575	33
<b>B. Capital Expense</b>			
34	Ownership	631,577	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	467,883	35
36	Provider Participation Fee	73,365	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	<b>\$ 6,790,528</b>	<b>40</b>
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	<b>327,246</b>	<b>41</b>
42	<b>Income Taxes</b>		<b>42</b>
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	<b>\$ 327,246</b>	<b>43</b>

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

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

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

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

Facility Name & ID Number Lake Cook Terrace Nursing Ctr

# 0039669

Report Period Beginning:

01/01/10

Ending:

12/31/10

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	2,009	2,048	\$ 85,524	\$ 41.76	1
2	Assistant Director of Nursing	2,058	2,098	69,862	33.30	2
3	Registered Nurses	17,553	19,946	597,996	29.98	3
4	Licensed Practical Nurses	13,752	15,764	479,094	30.39	4
5	CNAs & Orderlies	58,570	66,064	891,208	13.49	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	4,753	5,452	137,217	25.17	8
9	Activity Director					9
10	Activity Assistants	2,889	3,156	49,402	15.65	10
11	Social Service Workers	10,452	11,932	247,783	20.77	11
12	Dietician					12
13	Food Service Supervisor	2,084	2,198	51,149	23.27	13
14	Head Cook					14
15	Cook Helpers/Assistants	18,990	20,924	213,188	10.19	15
16	Dishwashers					16
17	Maintenance Workers	9,288	10,076	121,767	12.08	17
18	Housekeepers	21,063	23,197	217,086	9.36	18
19	Laundry	6,689	7,501	74,190	9.89	19
20	Administrator	1,881	1,980	118,571	59.88	20
21	Assistant Administrator					21
22	Other Administrative	2,040	2,080	67,178	32.30	22
23	Office Manager					23
24	Clerical	1,713	1,819	36,055	19.82	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	2,159	2,258	32,509	14.40	31
32	Other Health Care(specify)					32
33	Other(specify) <u>See Supplemental</u>	1,882	1,967	23,933	12.17	33
34	TOTAL (lines 1 - 33)	179,825	200,460	\$ 3,513,712 *	\$ 17.53	34

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

\*\* See instructions.

B. CONSULTANT SERVICES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference		
35	Dietary Consultant	Monthly	\$ 5,280	01-03	35
36	Medical Director	Monthly	3,900	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	7,255	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	103	5,875	12-03	45
46	Other(specify)				46
47	<u>Contract Dietary</u>	8	393	01-03	47
48					48
49	TOTAL (lines 35 - 48)	111	\$ 22,703		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

SEE ACCOUNTANTS' COMPILATION REPORT



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

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
FY2007					FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015	
1			\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	<b>TOTALS</b>		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name &amp; ID Number Lake Cook Terrace Nursing Ctr

# 0039669

Report Period Beginning:

01/01/10

Ending:

12/31/10

**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. ICLTC: \$5,862.58
- (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? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes  
What was the average life used for new equipment added during this period? 10 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 44,834 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. \$ 73,365  
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. \$ 29,383 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? 100% Ln 14  
d. Have vehicle usage logs been maintained? N/A  
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? 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: N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? N/A  
Attach invoices and a summary of services for all architect and appraisal fees.