FOR BHF USE

LL1

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.

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

I. IDPH License ID Number: 0026484

Facility Name: LAKEVIEW NURSING & REHABILITATION CENTRE

Address: 735 WEST DIVERSEY (Number) CHICAGO (City) 60614 (Zip Code)

County: COOK

Telephone Number: (847) 418-3801 **Fax #** (847) 418-3807

HFS ID Number:

Date of Initial License for Current Owners: 08/14/81

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: BOB KAGDA **Telephone Number:** (847) 675-3585
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2010 to 12/31/2010 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.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)
(Type or Print Name) JOHN BERNARDI
(Title) CFO

Paid Preparer

(Signed) (SEE ATTACHED ACCOUNTANTS' REPORT) (Date)
(Print Name and Title) BOB KAGDA, VICE PRESIDENT
(Firm Name & Address) KRUPNICK, BOKOR, KAGDA & BROOKS, LTD, 3750 W DEVON, LINCOLNWOOD, IL 60712-1124
(Telephone) (847) 675-3585 Fax # (847) 675-5777

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

Facility Name & ID Number LAKEVIEW NURSING & REHABILITATION CENTRE # 0026484 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	178	Skilled (SNF)	178	64,970	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	178	TOTALS	178	64,970	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	7,912	589	8,129	16,630	8
9	SNF/PED					9
10	ICF	25,789	1,594		27,383	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	33,701	2,183	8,129	44,013	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 67.74%

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 [X]

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

I. On what date did you start providing long term care at this location?
Date started 08/15/81

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 08/14/81 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 178 and days of care provided 7,281

Medicare Intermediary ADMINISTAR

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/2010 Fiscal Year: 12/31/2010

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

Facility Name & ID Number LAKEVIEW NURSING & REHABILITATI(# 0026484 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	379,905	26,427	21,006	427,338		427,338		427,338			1
2	Food Purchase		296,762		296,762	(18,484)	278,278		278,278			2
3	Housekeeping	357,663	35,334		392,997		392,997		392,997			3
4	Laundry	75,978	21,329		97,307		97,307		97,307			4
5	Heat and Other Utilities			232,008	232,008		232,008	2,434	234,442			5
6	Maintenance	93,564	32,273	26,071	151,908		151,908	4,983	156,891			6
7	Other (specify):*			25,587	25,587		25,587		25,587			7
8	**TOTAL General Services**	907,110	412,125	304,672	1,623,907	(18,484)	1,605,423	7,417	1,612,840			8
	B. Health Care and Programs											
9	Medical Director			36,000	36,000		36,000		36,000			9
10	Nursing and Medical Records	2,831,597	452,937	8,970	3,293,504		3,293,504		3,293,504			10
10a	Therapy	141,586		36,685	178,271		178,271		178,271			10a
11	Activities	116,577	4,070	2,448	123,095		123,095		123,095			11
12	Social Services	73,668		6,973	80,641		80,641		80,641			12
13	CNA Training											13
14	Program Transportation			13,448	13,448		13,448		13,448			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	3,163,428	457,007	104,524	3,724,959		3,724,959		3,724,959			16
	C. General Administration											
17	Administrative	289,654		262,865	552,519		552,519	(262,865)	289,654			17
18	Directors Fees											18
19	Professional Services			146,476	146,476		146,476	4,524	151,000			19
20	Dues, Fees, Subscriptions & Promotions			77,270	77,270		77,270	(28,177)	49,093			20
21	Clerical & General Office Expenses	407,636	55,067	107,360	570,063		570,063	43,473	613,536			21
22	Employee Benefits & Payroll Taxes			1,142,277	1,142,277	18,484	1,160,761		1,160,761			22
23	Inservice Training & Education											23
24	Travel and Seminar			1,879	1,879		1,879		1,879			24
25	Other Admin. Staff Transportation			11,349	11,349		11,349	1,367	12,716			25
26	Insurance-Prop.Liab.Malpractice			154,111	154,111		154,111	18,412	172,523			26
27	Other (specify):*			862,355	862,355		862,355	(848,724)	13,631			27
28	**TOTAL General Administration**	697,290	55,067	2,765,942	3,518,299	18,484	3,536,783	(1,071,990)	2,464,793			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	4,767,828	924,199	3,175,138	8,867,165		8,867,165	(1,064,573)	7,802,592			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.

Facility Name & ID#: LAKEVIEW NURSING & REHABILITATION CEN #0026484 **Report Period Beginning: 01/01/2010** **Ending: 12/31/2010**

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
1	**DIETARY**			
	DIETITIAN CONSULTANT	XVIII B 35-2	17,547	
	REPAIRS & MAINTENANCE		3,459	
			0	21,006
3	**HOUSEKEEPING**			
			0	
			0	0
4	**LAUNDRY**			
	EQUIPMENT REPAIRS & MAINTENANCE		0	
			0	0
5	**HEAT & OTHER UTILITIES**			
	GAS HEAT		86,482	
	ELECTRICITY		91,839	
	WATER		24,530	
	CABLE TV - LOBBY		29,157	
			0	232,008
6	**MAINTENANCE**			
	GROUNDS MAINTENANCE		2,467	
	PAINTING & DECORATING		630	
	BUILDING REPAIRS		0	
	MAINTENANCE TRAVEL		0	
	EQUIPMENT MAINTENANCE & REPAIR		4,401	
	ELEVATOR MAINTENANCE & REPAIR		7,618	
	OUTSIDE LABOR		0	
	EXTERMINATING SERVICE		4,857	
	FIRE SERVICE		6,098	
			0	
			0	
			0	
			0	26,071
7	**OTHER**			
	SCAVENGER		25,587	
	SECURITY SERVICE		0	
			0	
			0	25,587
9	**MEDICAL DIRECTOR**			
	MEDICAL DIRECTOR FEES	XVIII B 36-2	36,000	36,000

LINE		SCHED REF		TOTAL
10	**NURSING**			
	CONTRACT NURSING	XVIII C 53-2		
	LABORATORY & XRAY EXPENSE		4,489	
	PURCHASED SERVICES		0	
	PSYCHO-SOCIAL CONSULTANT	XVIII B __-2	0	
	RESTORATIVE NURSING CONSULTAN	XVIII B 38-2	0	
	MEDICAL RECORDS CONSULTANT	XVIII B 37-2	2,200	
	PHARMACY CONSULTANT	XVIII B 39-2	2,281	
	UTILIZATION REVIEW FEES	XVIII B __-2	0	
	PHYSICIANS	XVIII B __-2	0	
	PSYCHIATRIC	XVIII B __-2	0	
	RN CONSULTANT	XVIII B 38-2	0	
			0	
			0	8,970
10a	**THERAPY**			
	PHYSICAL THERAPY SERVICES			
	SPEECH THERAPY SERVICES		0	
	OCCUPATIONAL THERAPY SERVICES		0	
	REHABILITATION CONSULTANT	XVIII B __-2	0	
	PHYSICAL THERAPY CONSULTANT	XVIII B 40-2	0	
	OCCUPATIONAL THERAPY CONSULTA	XVIII B 41-2	0	
	RESPIRATORY THERAPY CONSULTAN	XVIII B 42-2	0	
	SPEECH THERAPY CONSULTANT	XVIII B 43-2	0	
	THERAPY CONTRACT SERVICES		36,685	
				36,685
11	**ACTIVITIES**			
	CABLE TV - PATIENT ROOMS			
	ACTIVITY REHAB CONSULTANT	XVIII B 44-2	2,448	
			0	2,448
12	**SOCIAL SERVICES**			
	SOCIAL REHABILITATION SERVICES			
	SOCIAL REHABILITATION CONSULTAN	XVIII B 45-2	0	
	SOCIAL WORKER	XVIII B 45-2	6,973	
			0	6,973
13	**NURSE AIDE TRAINING**			
	NURSE AIDE TRAINING COSTS	XIII	0	0

Facility Name & ID Number LAKEVIEW NURSING & REHABILITATION CENTRE #0026484 **Report Period Beginning:** 01/01/2010 **Ending:** 12/31/2010

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
14	**PROGRAM TRANSPORTATION**			
	PATIENT TRANSPORTATION		13,448	13,448
			0	
17	**ADMINISTRATIVE**			
	MANAGEMENT FEES	XIX B	262,865	262,865
	DIRECTORS FEES			
18	DIRECTORS FEES		0	0
19	**PROFESSIONAL SERVICES**			
	DATA PROCESSING	XIX C	18,281	
	ADMINISTRATIVE CONSULTANTS	XIX C	0	
	PROFESSIONAL FEES	XIX C	128,195	
			0	146,476
20	**FEES,SUBSCRIPTIONS,PROMOTIONS**			
	ENTERTAINMENT & MARKETING	VI 19 XIX F	20,361	
	ADV & PROMO-NON PATIENT RELATED	VI 25 XIX F	4,447	
	EMPLOYEE WANT ADS	XIX F	22,514	
	CONTRIBUTIONS	VI 20 XIX F	50	
	DUES & SUBSCRIPTIONS	XIX F	18,548	
	LICENSES & PERMITS	XIX F	3,070	
	PUBLIC RELATIONS-PATIENT RELATED	XIX F	0	
	ADVERTISING-YELLOW PAGES	VI 28 XIX F	2,464	
	TRUST FEES / FRANCHISE TAX / ETC	VI 17 XIX F	0	
	CONTRIBUTIONS - POLITICAL	VI 20 XIX F	2,000	
	HEALTH CARE WORKER BACKGROUND CHEC	XIX F	1,963	
	PATIENT BACKGROUND CHECKS	XIX F	1,853	
				77,270
21	**CLERICAL & GENERAL OFFICE EXPENSES**			
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)		6,328	
	EQUIPMENT REPAIR & MAINTENANCE		18,140	
	OUTSIDE CLERICAL SERVICES		23,998	
	PENALTIES / OVERDRAFT CHARGES	VI 18	8,066	
	HOME OFFICE EXPENSE		0	
	THEFT & DAMAGE LOSS		2,128	
	TELEPHONE		41,671	
	MESSENGER SERVICE		7,029	
			0	107,360

LINE		SCHED REF		TOTAL
22	**EMPLOYEE BENEFITS & PAYROLL TAXES**			
	FICA TAXES	XIX D	361,790	
	UNEMPLOYMENT COMPENSATION	XIX D	81,837	
	WORKERS COMPENSATION INSURANC	XIX D	234,885	
	HOSPITALIZATION INSURANCE	XIX D	412,457	
	EMPLOYEE BENEFITS - OTHER	XIX D	1,777	
	EMPLOYEE PHYSICAL EXAMS	XIX D	0	
	INSURANCE - EXECUTIVE LIFE	VI 21/XIX D	0	
	PENSION/PROFIT SHARING PLANS	XIX D	42,331	
	CHICAGO HEAD TAX	XIX D	7,200	
			0	1,142,277
23	**INSERVICE TRAINING & EDUCATION**			
	EDUCATION & SEMINARS		0	
				0
24	**TRAVEL & SEMINARS**			
	EDUCATION & SEMINARS	XIX G	1,879	
	TRAVEL	XIX G	0	
				1,879
25	**ADMIN. STAFF TRANSPORTATION**			
	TRANSPORTATION - STAFF		11,349	
				11,349
26	**INSURANCE - PROP. LIAB & MALPRACTICE**			
	GENERAL INSURANCE		154,111	
				154,111
27	**OTHER**			
	BAD DEBTS	VI 24	862,355	
				862,355

GRAND TOTAL COLUMN 3 OTHER **3,175,138**

LAKEVIEW NURSING & REHABILITATION CENTRE
SCHEDULES
12/31/2010

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

TOTAL FOOD PURCHASE	296,762
LESS SALES TAX	0
NET FOOD	296,762
TOTAL PATIENT CENSUS	44,013
TIME 3 MEALS PER DAY	3
TOTAL PATIENT MEALS	132,039
ADD # EMPLOYEE MEALS/DAY	24
TIME # DAYS	365
TOTAL EMPLOYEE MEALS	8,760
PATIENT MEALS	132,039
ADD EMPLOYEE MEALS	8,760
TOTAL MEALS/YEAR	140,799
NET FOOD	296,762
DIVIDE TOTAL MEALS/YEAR	140,799
COST PER MEAL	2.11
TIME EMPLOYEE MEALS	8,760
EMPLOYEE MEAL RECLASSIFICATION	**18,484**
	========

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

Facility Name & ID Number LAKEVIEW NURSING & REHABILITATION CENTRE #0026484 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			116,814	116,814		116,814	253,640	370,454			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			116,925	116,925		116,925	397,490	514,415			32
33	Real Estate Taxes							262,770	262,770			33
34	Rent-Facility & Grounds			992,619	992,619		992,619	(992,619)				34
35	Rent-Equipment & Vehicles			72,792	72,792		72,792		72,792			35
36	Other (specify):* **RENT OFFICE**			38,774	38,774		38,774	67,517	106,291			36
37	**TOTAL Ownership**			1,337,924	1,337,924		1,337,924	(11,202)	1,326,722			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		316,446	468,670	785,116		785,116		785,116			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			97,455	97,455		97,455		97,455			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		316,446	566,125	882,571		882,571		882,571			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	4,767,828	1,240,645	5,079,187	11,087,660		11,087,660	(1,075,775)	10,011,885			45

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

Facility Name & ID Number LAKEVIEW NURSING & REHABILITATION CENTR # 0026484 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	43,041	30		9
10	Interest and Other Investment Income	(199)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax		2		13
14	Non-Care Related Interest		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	(8,066)	21		18
19	Entertainment	(20,361)	20		19
20	Contributions	(2,050)	20		20
21	Owner or Key-Man Insurance		22		21
22	Special Legal Fees & Legal Retainers	(5,000)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(862,355)	27		24
25	Fund Raising, Advertising and Promotional	(4,447)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(2,464)	20		28
29	Other-Attach Schedule SEE PAGE 5A	(73,774)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (935,675)		$	30

BHF USE ONLY									
48		49		50		51		52	

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

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(140,100)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (140,100)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (1,075,775)		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 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

LAKEVIEW NURSING & REHABILITATION CENTRE

ID# 0026484

Report Period Beginning: 01/01/2010

Ending: 12/31/2010

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1		$		1
2	MARKETING SALARIES	(73,774)	21	2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
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26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(73,774)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number LAKEVIEW NURSING & REHABILITATION CENTRE # 0026484 **Report Period Beginning:** 01/01/2010 **Ending:** 12/31/2010

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 TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	2,434	0	0	0	0	0	0	0	0	2,434	5
6	Maintenance	0	0	4,983	0	0	0	0	0	0	0	0	4,983	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	0	0	7,417	0	0	0	0	0	0	0	0	7,417	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	(262,865)	0	0	0	0	0	0	0	0	(262,865)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(5,000)	0	9,524	0	0	0	0	0	0	0	0	4,524	19
20	Fees, Subscriptions & Promotions	(29,322)	0	1,145	0	0	0	0	0	0	0	0	(28,177)	20
21	Clerical & General Office Expenses	(81,840)	0	125,313	0	0	0	0	0	0	0	0	43,473	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	1,367	0	0	0	0	0	0	0	0	1,367	25
26	Insurance-Prop.Liab.Malpractice	0	17,507	905	0	0	0	0	0	0	0	0	18,412	26
27	Other (specify):*	(862,355)	0	13,631	0	0	0	0	0	0	0	0	(848,724)	27
28	**TOTAL General Administration**	(978,517)	17,507	(110,980)	0	0	0	0	0	0	0	0	(1,071,990)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(978,517)	17,507	(103,563)	0	0	0	0	0	0	0	0	(1,064,573)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number LAKEVIEW NURSING & REHABILITATION CENTRE # 0026484 **Report Period Beginning:** 01/01/2010 **Ending:** 12/31/2010

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 TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	43,041	210,599	0	0	0	0	0	0	0	0	0	253,640	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(199)	396,842	847	0	0	0	0	0	0	0	0	397,490	32
33	Real Estate Taxes	0	262,770	0	0	0	0	0	0	0	0	0	262,770	33
34	Rent-Facility & Grounds	0	(992,619)	0	0	0	0	0	0	0	0	0	(992,619)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	46,620	20,897	0	0	0	0	0	0	0	0	67,517	36
37	TOTAL Ownership	42,842	(75,788)	21,744	0	0	0	0	0	0	0	0	(11,202)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(935,675)	(58,281)	(81,819)	0	0	0	0	0	0	0	0	(1,075,775)	45

Facility Name & ID Number LAKEVIEW NURSING & REHABILITATION CENTRE # 0026484 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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
				BOREK &	GLENVIEW	LAW FIRM
SAM BOREK	50			GOLDHIRSCH		
HILLARD GARLOVSKY	50			CONSULTANT FOR	GLENVIEW	MGMT/CLERICAL
				CORPORATE MGMT		
				735 W. DIVERSEY	CHICAGO	REAL ESTATE
				BUILDING, LLC		

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. [X] YES [ ] NO

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	RENT	$ 992,619	735 WEST DIVERSEY BUILDING, LLC		$	$ (992,619)	1
2	V	30	SL DEPRECIATION				210,599	210,599	2
3	V	32	INTEREST				396,842	396,842	3
4	V	33	REAL ESTATE TAX				262,770	262,770	4
5	V	36	MIP INSURANCE				46,620	46,620	5
6	V	26	INSURANCE				17,507	17,507	6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 992,619			$ 934,338	$ * (58,281)	14

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

Facility Name & ID Number LAKEVIEW NURSING & REHABILITATION CENTRE # 0026484 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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. [X] YES [ ] NO

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	17	MANAGEMENT FEES	$ 262,865	CONSULTANT FOR CORPORATE MANAGEMENT		$	$ (262,865)	15
16	V	5	UTILITIES				2,434	2,434	16
17	V	6	MAINTENANCE & REPAIR				4,983	4,983	17
18	V	19	PROFESSIONAL FEES				9,524	9,524	18
19	V	20	DUES, FEES,SUBSCRIPTIONS				1,145	1,145	19
20	V	21	TOTAL OFFICE				125,313	125,313	20
21	V	25	TRANSPORTATION				1,367	1,367	21
22	V	26	INSURANCE				905	905	22
23	V	27	EMPLOYEE BENEFITS				13,631	13,631	23
24	V	32	INTEREST				847	847	24
25	V	36	OFFICE AND STORAGE RENT				20,897	20,897	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			$ 262,865			$ 181,046	$ * (81,819)	39

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

Facility Name & ID Number LAKEVIEW NURSING & REHABILITAT # 0026484 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	SAM BOREK	PRESIDENT	ADMINISTRAT.	50.00		30	60.00	SALARY	$ 145,807	17-1	1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 145,807		13

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

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

Facility Name & ID Number LAKEVIEW NURSING & REHABILITATION CENTRE # 0026484 Report Period Beginning: 01/01/2010 Ending: 2/31/2010

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 [X] NO [ ]

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

Name of Related Organization: CONSULTANTS FOR CORPORATE MGMT
Street Address: 2638 PATRIOT BLVD, SUITE 100
City / State / Zip Code: GLENVIEW, IL 60026
Phone Number: ((847) 256-7600
Fax Number: ((847) 251-5544

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	UTILITIES	DIRECT COST			$ 2,434	$		$ 2,434	1
2	6	MAINTENANCE & REPAIR	DIRECT COST			4,983			4,983	2
3	19	PROFESSIONAL FEES	DIRECT COST			9,524			9,524	3
4	20	DUES, FEES,SUBSCRIPTIONS	DIRECT COST			1,145			1,145	4
5	21	TOTAL OFFICE	DIRECT COST			125,313	84,763		125,313	5
6	25	TRANSPORTATION	DIRECT COST			1,367			1,367	6
7	26	INSURANCE	DIRECT COST			905			905	7
8	27	EMPLOYEE BENEFITS	DIRECT COST			13,631			13,631	8
9	32	INTEREST	DIRECT COST			847			847	9
10	36	OFFICE AND STORAGE RENT	DIRECT COST			20,897			20,897	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					$ 181,046	$ 84,763		$ 181,046	25

Facility Name & ID Number LAKEVIEW NURSING & REHABILITATI(# 0026484 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	RELATED PARTY: 735 DIVERSEY BUILDING, LLC						$	$			$	1
2	CAMBRIDGE REALTY		X	MORTGAGE	$77,801.29	05/04	10,055,500	9,395,447	05/39	5.6000	396,842	2
3	LOAN COSTS		X	LOAN COSTS	W/O OVER LOAN		199,085					3
4	PROVIDENCE CAPITAL		X	EQUIPMANT LEASE	$23,085.00	11/07	950,226	264,473	12/11	8.6450	34,374	4
5	MGMT ALLOCATION										847	5
	Working Capital											
6	BANK FINANCIAL	X		WORKING CAPITAL	DEMAND	12/07	2,412,203			PRIME+	70,061	6
7	GLENVIEW STATE BANK		X	AUTO LOAN	$276.94	05/09	13,270	9,477	04/14	9.4090	1,167	7
8	MEPCO INSURANCE		X	INSURANCE FINANCE							11,323	8
9	TOTAL Facility Related				$101,163.23		$ 13,630,284	$ 9,669,397			$ 514,614	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 13,630,284	$ 9,669,397			$ 514,614	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$** 46,620 **Line #** 36

*** 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.)**

Facility Name & ID Number LAKEVIEW NURSING & REHABILITATION CENTRE # 0026484 **Report Period Beginning:** 01/01/2010 **Ending:** 12/31/2010

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2009 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 178,400	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$ 218,985	2
3. Under or (over) accrual (line 2 minus line 1).		$ 40,585	3
4. Real Estate Tax accrual used for 2010 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 222,185	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 262,770	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2005	165,414	8
	2006	170,014	9
	2007	168,199	10
	2008	169,887	11
	2009	218,985	12

THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED ON ~ 101% OF THE PRIOR YEAR REAL ESTATE TAX BILL

THE PAYMENT ON LINE 2 APPLIES TO THE 2009 TAX BILL.

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2009	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

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.

2009 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME LAKEVIEW NURSING & REHABILITATION CENTRE COUNTY COOK

FACILITY IDPH LICENSE NUMBER 0026484

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 2009 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 2009.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	14-28-300-013-0000	NURSING HOME	$ 218,984.94	$ 218,984.94
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 218,984.94	$ 218,984.94

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 2009 tax bills which were listed in Section A to this statement. Be sure to use the 2009 tax bill which is normally paid during 2010.

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

Facility Name & ID Number LAKEVIEW NURSING & REHABILITATION CENTRE # 0026484 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

X. BUILDING AND GENERAL INFORMATION:

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

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (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? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

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

N/A

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

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

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

XI. OWNERSHIP COSTS:

A. Land.

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

Facility Name & ID Number LAKEVIEW NURSING & REHABILITATION CENTRE # 0026484 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	178		2001		$ 5,022,332	$ 128,778	39	$ 128,778	$	$ 1,261,101	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	LEASEHOLD IMPROVEMENTS			1982	2,850					2,850	9
10	LEASEHOLD IMPROVEMENTS			1983	2,500		15			2,500	10
11	LEASEHOLD IMPROVEMENTS			1985	2,312		10			2,312	11
12	LEASEHOLD IMPROVEMENTS			1985	3,200		20			3,200	12
13	LEASEHOLD IMPROVEMENTS			1987	29,042	922	20		(922)	29,042	13
14	LEASEHOLD IMPROVEMENTS			1987	8,647	275	31.5	275		6,321	14
15	LEASEHOLD IMPROVEMENTS			1988	13,520	429	31.5	429		9,787	15
16	LEASEHOLD IMPROVEMENTS			1989	17,460	554	5		(554)	17,460	16
17	LEASEHOLD IMPROVEMENTS			1989	6,534	207	15		(207)	6,534	17
18	LEASEHOLD IMPROVEMENTS			1990	20,612	654	31.5	654		13,734	18
19	LEASEHOLD IMPROVEMENTS			1991	40,916	1,299	31.5	1,299		25,330	19
20	LEASEHOLD IMPROVEMENTS			1992	40,819	1,296	31.5	1,296		24,044	20
21	LEASEHOLD IMPROVEMENTS			1993	10,482	333	31.5	333		5,939	21
22	LEASEHOLD IMPROVEMENTS			1993	16,965	435	39	435		7,478	22
23	LEASEHOLD IMPROVEMENTS			1994	9,602	246	39	246		4,111	23
24	ROOF REPAIR			1995	3,188	82	39	82		1,276	24
25	SHOWER RECONSTRUCTION			1995	7,775	200	39	200		3,002	25
26	SHOWER ROOMS RENOVATION			1996	35,634	914	39	914		13,337	26
27	OFFICE CONSTRUCTION			1996	4,647	119	39	119		1,719	27
28	ELECTRIC SLIDING DOOR			1996	1,380	35	39	35		496	28
29	BRICKWORK/TUCKPOINT			1997	1,680	43	39	43		589	29
30	PARKING LOT			1997	1,900	49	39	49		770	30
31	CLOSET WORK			1997	800	20	39	20		277	31
32	CONSULTING AND INSTALL FIREDOORS			1997	23,621	606	39	606		7,949	32
33	FIRE ALARM PANEL			1998	3,500	90	39	90		1,151	33
34	ROOF EXHAUST FANS, INSTALLATION FIRE DAMPTERS			1998	20,698	531	39	531		6,745	34
35	FRONT PORCH ENTRANCE, ONE MARQUEE CANOPY			1998	2,247	57	39	57		718	35
36	SMOKE DAMPERS			1998	1,669	43	39	43		532	36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number LAKEVIEW NURSING & REHABILITATION CENTRE # 0026484 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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	
37	WALK IN FREEZER-NEW CONDENSING UNIT	1998	$ 5,546	$ 142	39	$ 142	$	$ 1,734	37
38	CEILING & LIGHT FIXTURES, ELECTRICAL	1998	30,226	775	39	775		9,334	38
39	CAFETERIAS - 1ST AND 3RD FLOOR	1999	3,000	77	39	77		914	39
40	LIGHTING, ELECTRICAL WORK, INSTALL CABLE	1999	27,482	705	39	705		8,349	40
41	DOORS REPAIR & PAINT-1ST,2ND AND 3RD FLOOR	1999	25,070	643	39	643		7,501	41
42	PLUMBING ROUGH	1999	10,300	264	39	264		3,091	42
43	PAINT WORK-1ST,END,3RD FLOOR, BASEMENT	1999	21,014	539	39	539		6,176	43
44	WALLCOVERING, CARPET TILES	1999	55,627	1,426	39	1,426		16,385	44
45	GENERATOR EXHAUST PIPE	1999	2,300	59	39	59		686	45
46	HANDRAILS-1ST,2ND,3RD FLOOR, BASEMENT	1999	24,340	624	39	624		7,226	46
47	ALARM SYSTEM	1999	107,758	2,763	39	2,763		32,530	47
48	DINING ROOM - 2ND AND 3RD FLOOR	1999	12,206	313	39	313		3,589	48
49	SHOWER AND FRONT STOOP REPAIR	1999	4,300	110	39	110		1,254	49
50	WINDOWS, CLOSETS, EXTERIOR	1999	4,415	113	39	113		1,204	50
51	INSTALLATION OF THE FIRE DAMPERS	1999	5,880	151	39	151		1,793	51
52	PLEATED SHADES	2000	949		20	47	47	517	52
53	CANVAS CANOPY	2000	3,996	102	39	102		1,103	53
54	INSTALLATION OF COOLING TOWER	2000	24,450	627	39	627		6,713	54
55	ALARM SYSTEM - ADDITIONAL PROTECTION	2000	1,970	51	39	51		546	55
56	DIALYSIS ROOM EXTRA CIRCUITS	2000	1,983	51	39	51		546	56
57	MICROLIGHT DETECTORS	2000	3,800	97	39	97		1,019	57
58	REPAIR DRYWALL	2000	3,744	96	39	96		985	58
59	ELECTRICAL PANEL FOR DIALYSIS CENTER	2000	2,380	61	39	61		623	59
60	INSTALLED 9 DOOR HOLDERS	2000	3,465	89	39	89		901	60
61	REMODELING NEW NORTHFIELD OFFICE	2001	3,440	88	39	88		877	61
62	TWO PASSENGER ELEVATOR	2001	84,711	2,172	39	2,172		20,363	62
63	TUCKPOINTING	2001	3,160	81	39	81		746	63
64	REPAVE DRIVEWAY & PARKING LOT	2001	7,000	179	39	179		1,672	64
65	ELECTRICAL WORK	2001	11,922	306	39	306		2,803	65
66	ROOF REPAIR	2001	7,945	204	39	204		1,893	66
67	PAINTING, WALLPAPERING, DRYWALL	2001	42,598	1,092	39	1,092		11,993	67
68	BACKUP GENERATOR	2002	6,375	163	39	163		1,461	68
69	ELECTRICAL WORK	2002	5,000	128	39	128		1,147	69
70	TOTAL (lines 4 thru 69)		$ 5,914,884	$ 152,508		$ 150,872	$ (1,636)	$ 1,617,978	70

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

Facility Name & ID Number LAKEVIEW NURSING & REHABILITATION CENTRE # 0026484 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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	Totals from Page 12A, Carried Forward		$ 5,914,884	$ 152,508		$ 150,872	$ (1,636)	$ 1,617,978	1
2	ROOF & GUTTER REPAIR	2002	7,000	180	39	180		1,612	2
3	FLOORING & TILE IN CAFETERIA	2002	5,368	138	20	268	130	2,412	3
4	REPAIR DRIVEWAY & PARKING LOT	2002	3,300	85	15	220	135	1,980	4
5	CABINET INSTALLATION IN MAINTENANCE ROOM	2002	3,200	82	39	82		721	5
6	CARPETING INSTALLATION IN WAITING AREA	2002	3,561	91	20	178	87	1,602	6
7	REPLACE CABLE IN ELEVATOR	2002	5,800	149	39	149		1,297	7
8	BATHROOM SHOWER	2003	8,075	207	39	207		1,561	8
9	BOILER RE-TUBING	2003	21,850	560	39	560		4,130	9
10	CARPETING AND SHADES	2003	5,186		20	259	259	2,072	10
11	PLUMBING REVISIONS FOR DIALYSIS LOOP PIPING	2004	14,993	545	27.5	545		3,520	11
12	SPRINKLER SYSTEM & FIRE ALARM REPAIR	2005	6,556	238	27.5	238		1,339	12
13	ASPHALT PAVEMENT	2006	3,859	257	15	257		1,285	13
14	SLIDING DOORS & CIRCUIT TO A NEW DOOR OPENER	2006	5,890	214	27.5	214		954	14
15	BUILDING RENOVATION AND REMODELING:	2006	685,986	24,945	27.5	24,945		111,213	15
16	BUIL-IN WARDROBE,WALLCOVERING, TILES, FLOORING,								16
17	1-ST FLOOR LOBBY, DINING ROOM, PHYSICAL THERAPY ROOM,								17
18	NEW CELLINGS, CUSTOM NURSING STATION, BEAUTY SHOP,								18
19	ADMISSION AND ACCOUNTING OFFICE, WALL MOUNTED								19
20	FOUNTAIN, RESIDENT BATHROOM, ACCENT WALL FOR								20
21	CONFERENCE ROOM								21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 6,695,508	$ 180,199		$ 179,174	$ (1,025)	$ 1,753,676	34

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

Facility Name & ID Number LAKEVIEW NURSING & REHABILITATION CENTRE # 0026484 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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	Totals from Page 12B, Carried Forward		$ 6,695,508	$ 180,199		$ 179,174	$ (1,025)	$ 1,753,676	1
2	735 WEST DIVERSEY BUILDING LLC								2
3	REPLACE 100 TON CHILLER	2007	114,700	11,470	10	11,470			3
4	SEAL COAT ASPHALT RAMP, TUCKPOINTING	2007	10,500	1,050	10	1,050			4
5	INSTALLED TWO OUTDOOR WALL SCONCE,LANTERN	2007	5,243	524	10	524			5
6	INSTALLATION OF ADDT'L SMOKE DETECTOR	2007	3,650	365	10	365			6
7	REPLACE HYDRAULIC CYLINDER FOR ELEVATOR	2007	64,756	6,476	10	6,476			7
8	INSTALL NEW SET OF ROLLER GUIDES ON ELEVATOR	2007	3,169	317	10	317			8
9	DIALYSIS ROOM - FLOORING	2008	3,518	352	10	352			9
10	ELEVATOR-REPLACE DELTA RELAY IN CONTROLLER	2008	2,946	294	10	294			10
11	INSTALL REMOTE ANNUNCIATER	2008	4,033	403	10	403			11
12	CHILLER-INSTALL VENTILATION & MONITORING SYSTE	2008	20,223	2,022	10	2,022			12
13	REPAIR BRICK AND FURNISH 1100 NEW UTILITY BRICK	2009	24,475	716	10	716			13
14	INSTALL FIRE DAMPERS	2010	7,450	745	10	745			14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 6,960,171	$ 204,933		$ 203,908	$ (1,025)	$ 1,753,676	34

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

Facility Name & ID Number LAKEVIEW NURSING & REHABILITATION CE# 0026484 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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	$ 2,592,822	$ 55,368	$ 106,105	$ 50,737	3-15	$ 546,300	71
72	Current Year Purchases							72
73	Fully Depreciated Assets	840,746					840,746	73
74	RELATED PARTY DEPRECIATION		57,087	57,087				74
75	TOTALS	$ 3,433,568	$ 112,455	$ 163,192	$ 50,737		$ 1,387,046	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	ADMINISTRATIVE	1999 BLAZER	1999	$ 34,882	$ 1,775	$	$ (1,775)	5	$ 34,882	76
77	ADMINISTRATIVE	1999 MERSEDES	2001	53,242	1,775		(1,775)	5	53,242	77
78	ADMINISTRATIVE	2004 LEXUS	2004	43,476	1,675		(1,675)	5	43,476	78
79	ADMINISTRATIVE	2007 SUBARU IMPREZA	2009	16,770	4,800	3,354	(1,446)	5	6,708	79
80	TOTALS			$ 148,370	$ 10,025	$ 3,354	$ (6,671)		$ 138,308	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)	$ 11,100,146	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 327,413	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 370,454	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 43,041	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 3,279,030	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.

Facility Name & ID Number LAKEVIEW NURSING & REHABILITATION CENTRE # 0026484 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

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

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

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

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: *

10. Effective dates of current rental agreement:
Beginning
Ending

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

	Fiscal Year Ending	Annual Rent
12.		$
13.		$
14.		$

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

15. Is Movable equipment rental included in building rental? ☐ YES ☒ NO

16. Rental Amount for movable equipment: $ 49,307 Description: SEE SCHEDULE ATTACHED
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	ADMINISTRATIVE	2009 PORSCHE	$ #######	$ 15,376	17
18	DON	2005 JEEP CHEROKEE	411.25	817	18
19	ADMINISTRATIVE	2004 TOYOTA WAGON	614.52	7,292	19
20					20
21	TOTAL		$ #######	$ 23,485	21

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

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

Facility Name & ID Number LAKEVIEW NURSING & REHABILITATION CENTRE # 0026484 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

   THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		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	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF CNAs TRAINED

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

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

Facility Name & ID Number LAKEVIEW NURSING & REHABILITATION CENTRE # 0026484 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39-3	hrs	$		$ 188,254	$		$ 188,254	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			51,423			51,423	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			228,993			228,993	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescrpts				299,969		299,969	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Radiology, Laboratory Other (specify): OTHERS	39-2 39-2					14,528 1,949		14,528 1,949	13
14	TOTAL		$		$ 468,670		$ 316,446		$ 785,116	14

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

Facility Name & ID Number LAKEVIEW NURSING & REHABILITATION CENTRE # 0026484 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2010 (last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 156,407	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,871,656		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	165,465		6
7	Other Prepaid Expenses	41,179		7
8	Accounts Receivable (owners or related parties)	605,321		8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,840,028	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	1,673,176		15
16	Equipment, at Historical Cost	1,947,852		16
17	Accumulated Depreciation (book methods)	(2,320,190)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,300,838	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 4,140,866	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 2,722,751	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	9,211		28
29	Short-Term Notes Payable	313,909		29
30	Accrued Salaries Payable	194,009		30
31	Accrued Taxes Payable (excluding real estate taxes)	2,055,427		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 5,295,307	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	273,950		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 273,950	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 5,569,257	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (1,191,109)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 4,378,148	$	48

***(See instructions.)**

Facility Name & ID Number LAKEVIEW NURSING & REHABILITATION CENTRE # 0026484 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 611,181	1
2	Restatements (describe):		2
3	ROUNDING	(1)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 611,180	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(1,802,289)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (1,802,289)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (1,191,109)	24 *

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

Facility Name & ID Number LAKEVIEW NURSING & REHABILITATION CI # 0026484 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 8,920,710	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 8,920,710	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	362,796	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 362,796	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	199	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 199	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	VENDING COMMISSIONS	1,666	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 1,666	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 9,285,371	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,623,907	31
32	Health Care	3,724,959	32
33	General Administration	3,518,299	33
	B. Capital Expense		
34	Ownership	1,337,924	34
	C. Ancillary Expense		
35	Special Cost Centers	785,116	35
36	Provider Participation Fee	97,455	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 11,087,660	40
41	**Income before Income Taxes (line 30 minus line 40)****	(1,802,289)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (1,802,289)	43

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

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

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

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

Facility Name & ID Number LAKEVIEW NURSING & REHABILITATION CENTRE # 0026484 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,080	2,320	$ 100,444	$ 43.29	1
2	Assistant Director of Nursing	626	658	26,660	40.52	2
3	Registered Nurses	28,890	31,168	915,356	29.37	3
4	Licensed Practical Nurses	24,718	26,892	639,151	23.77	4
5	CNAs & Orderlies	87,324	93,251	934,905	10.03	5
6	CNA Trainees					6
7	Licensed Therapist	1,204	1,749	54,446	31.13	7
8	Rehab/Therapy Aides	6,970	7,435	87,140	11.72	8
9	Activity Director	2,000	2,167	35,844	16.54	9
10	Activity Assistants	9,762	10,254	80,733	7.87	10
11	Social Service Workers	3,848	4,185	73,668	17.60	11
12	Dietician					12
13	Food Service Supervisor	1,904	2,125	34,054	16.03	13
14	Head Cook					14
15	Cook Helpers/Assistants	28,598	31,462	345,851	10.99	15
16	Dishwashers					16
17	Maintenance Workers	3,957	4,384	93,564	21.34	17
18	Housekeepers	31,350	33,541	357,663	10.66	18
19	Laundry	6,712	7,704	75,978	9.86	19
20	Administrator	2,008	2,200	143,847	65.39	20
21	Assistant Administrator					21
22	Other Administrative	2,032	2,080	145,807	70.10	22
23	Office Manager	1,992	2,240	71,544	31.94	23
24	Clerical	14,280	14,942	262,318	17.56	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,920	2,088	37,543	17.98	31
32	Other Health C: SEE ATTACHED	7,249	7,584	177,538	23.41	32
33	Other(specify) MARKETING	2,488	2,624	73,774	28.12	33
34	TOTAL (lines 1 - 33)	271,912	293,053	$ 4,767,828 *	$ 16.27	34

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	Monthly	$ 17,547	1-3	35
36	Medical Director	Monthly	36,000	9-3	36
37	Medical Records Consultant	Monthly	2,200	10-3	37
38	Nurse Consultant	Monthly	0	10-3	38
39	Pharmacist Consultant	Monthly	2,281	10-3	39
40	Physical Therapy Consultant		0	10a-3	40
41	Occupational Therapy Consultant		0	10a-3	41
42	Respiratory Therapy Consultant		0	10a-3	42
43	Speech Therapy Consultant		0	10a-3	43
44	Activity Consultant	48	2,448	11-3	44
45	Social Service Consultant	127	6,973	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	175	$ 67,449		49

C. CONTRACT NURSES

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

Facility Name & ID Number LAKEVIEW NURSING & REHABILITATION CE # 0026484 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
MICHAEL ELKES	ADMINISTRATOR	0	$ 111,430
TED O'BRIEN	ADMINISTRATOR	0	32,417
SAM BOREK	PRESIDENT	50	145,807
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 289,654

B. Administrative - Other

Description	Amount
CONSULTANTS FOR CORPORATE MANAGEMENT	$ 262,865
TOTAL (agree to Schedule V, line 17, col. 3)	$ 262,865
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
SEE SCHEDULE ATTACHED		$ 146,476
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$ 146,476

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 234,885
Unemployment Compensation Insurance	81,837
FICA Taxes	361,790
Employee Health Insurance	412,457
Employee Meals	18,484
Illinois Municipal Retirement Fund (IMRF)*	
EMPLOYEE BENEFITS - OTHER	1,777
EMPLOYEE PHYSICAL EXAMS	0
PENSION/PROFIT SHARING PLANS	42,331
CHICAGO HEAD TAX	7,200
INSURANCE - EXECUTIVE LIFE	0
INSURANCE - EXECUTIVE LIFE VI 21	0
TOTAL (agree to Schedule V, line 22, col.8)	$ 1,160,761

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 995
Advertising: Employee Recruitment	22,514
Health Care Worker Background Check	1,963
(Indicate # of checks performed 191)	
Patient Background Checks 171	1,853
TRUST/FRANCHISE/CONTRIB/ETC	2,050
MARKETING/ADV/PROMO	27,272
LICENSES/DUES/SUBSCRIPTIONS	20,623
MGMT CO ALLOC	1,145
TRUST/FRANCHISE/CONTRIB/ETC	(2,050)
Less: Public Relations Expense	(20,361)
Non-allowable advertising	(4,447)
Yellow page advertising	(2,464)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 49,093

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
	0
Seminar Expense	
	1,879
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 1,879

**See instructions.

Facility Name & ID Number LAKEVIEW NURSING & REHABILITATION CENTR # 0026484 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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							N/A						
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number LAKEVIEW NURSING & REHABILITATION CENTRE # 0026484 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **YES**

(2) Are there any dues to nursing home associations included on the cost report? **YES**
If YES, give association name and amount. **IL COUNCIL ON LONG TERM CARE $ 16,554**

(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. $ **309** Line **10-2**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **97,455**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **NO** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **YES**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **NO** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **18,484** 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.