

Facility Name & ID Number LAKEVIEW LIVING CENTER

0028134 Report Period Beginning: 07/01/2003 Ending: 06/30/2004

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6	145	ICF/DD 16 or Less	145	53,070	6
7	145	TOTALS	145	53,070	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 Public Aid Recipient	4 Private Pay	Other		
8	SNF					8
9	SNF/PED					9
10	ICF					10
11	ICF/DD	47,013	366		47,379	11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	47,013	366		47,379	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 89.28%

D. How many bed-hold days during this year were paid by Public Aid?

933 (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 05/23/83

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

YES Date 12/01/88 NO

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

YES NO If YES, enter number of beds certified 0 and days of care provided N/A

Medicare Intermediary N/A

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 06/30/04 Fiscal Year: 06/30/04

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

STATE OF ILLINOIS

Facility Name & ID Number LAKEVIEW LIVING CENTER # 0028134 Report Period Beginning: 07/01/2003 Ending: 06/30/2004

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 OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	216,404	32,052	13,566	262,022		262,022	500	262,522		1
2	Food Purchase		180,465		180,465		180,465		180,465		2
3	Housekeeping	86,767	35,595		122,362		122,362		122,362		3
4	Laundry	50,928	22,137	2,259	75,324		75,324		75,324		4
5	Heat and Other Utilities			113,684	113,684		113,684	2,197	115,881		5
6	Maintenance	78,924		42,995	121,919		121,919	178	122,097		6
7	Other (specify):*										7
8	TOTAL General Services	433,023	270,249	172,504	875,776		875,776	2,875	878,651		8
	B. Health Care and Programs										
9	Medical Director										9
10	Nursing and Medical Records	2,354,648	48,059	62,557	2,465,264		2,465,264	14,200	2,479,464		10
10a	Therapy			24,291	24,291		24,291		24,291		10a
11	Activities		2,704		2,704		2,704		2,704		11
12	Social Services	23,060		32,713	55,773		55,773		55,773		12
13	Nurse Aide Training	21,710	500		22,210		22,210		22,210		13
14	Program Transportation			13,870	13,870		13,870		13,870		14
15	Other (specify):* ER DENTAL			550	550		550		550		15
16	TOTAL Health Care and Programs	2,399,418	51,263	133,981	2,584,662		2,584,662	14,200	2,598,862		16
	C. General Administration										
17	Administrative	67,645		368,629	436,274		436,274	(56,995)	379,279		17
18	Directors Fees			14,425	14,425		14,425	11,249	25,674		18
19	Professional Services			51,631	51,631		51,631	13,426	65,057		19
20	Dues, Fees, Subscriptions & Promotions			14,529	14,529		14,529	2,867	17,396		20
21	Clerical & General Office Expenses	107,218	16,526	49,177	172,921		172,921	77	172,998		21
22	Employee Benefits & Payroll Taxes			613,264	613,264		613,264	61,873	675,137		22
23	Inservice Training & Education			22,930	22,930		22,930	15,979	38,909		23
24	Travel and Seminar			3,905	3,905		3,905	1,332	5,237		24
25	Other Admin. Staff Transportation			5,792	5,792		5,792	277	6,069		25
26	Insurance-Prop.Liab.Malpractice			43,803	43,803		43,803	2,108	45,911		26
27	Other (specify):*										27
28	TOTAL General Administration	174,863	16,526	1,188,085	1,379,474		1,379,474	52,193	1,431,667		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,007,304	338,038	1,494,570	4,839,912		4,839,912	69,268	4,909,180		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 Number

LAKEVIEW LIVING CENTER

#0028134

Report Period Beginning:

07/01/2003

Ending:

06/30/2004

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			136,870	136,870		136,870	7,044	143,914			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			302,735	302,735		302,735	(30,681)	272,054			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds							11,847	11,847			34
35	Rent-Equipment & Vehicles			16,860	16,860		16,860	448	17,308			35
36	Other (specify):*											36
37	TOTAL Ownership			456,465	456,465		456,465	(11,342)	445,123			37
	Ancillary Expense											
	E. Special Cost Centers											
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			351,288	351,288		351,288		351,288			42
43	Other (specify):*			1,574,165	1,574,165		1,574,165	(1,574,165)				43
44	TOTAL Special Cost Centers			1,925,453	1,925,453		1,925,453	(1,574,165)	351,288			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,007,304	338,038	3,876,488	7,221,830		7,221,830	(1,516,239)	5,705,591			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 LIVING CENTER

0028134

Report Period Beginning: 07/01/2003

Ending: 06/30/2004

VI. ADJUSTMENT DETAIL

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

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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs	(1,532,117)	43		3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space	(2,825)	6		6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(17,561)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest	(3,237)	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees	(28,909)	43		17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(16,780)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (1,601,429)		\$	30

OHF 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	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	85,190		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 85,190		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (1,516,239)		37

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

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

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

LAKEVIEW LIVING CENTER

ID# 0028134

Report Period Beginning: 07/01/2003

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Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference
1	N/A	\$	1
2			2
3			3
4			4
5			5
6			6
7			7
8			8
9			9
10			10
11			11
12			12
13			13
14			14
15			15
16			16
17			17
18			18
19			19
20			20
21			21
22			22
23			23
24			24
25			25
26			26
27			27
28			28
29			29
30			30
31			31
32			32
33			33
34			34
35			35
36			36
37			37
38			38
39			39
40			40
41			41
42			42
43			43
44			44
45			45
46			46
47			47
48			48
49	Total	0	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number LAKEVIEW LIVING CENTER

0028134 Report Period Beginning:

07/01/2003

Ending:

06/30/2004

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

	Operating Expenses	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)	
	A. General Services													
1	Dietary	0	0	500	0	0	0	0	0	0	0	0	500	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	2,197	0	0	0	0	0	0	0	0	2,197	5
6	Maintenance	(2,825)	0	3,003	0	0	0	0	0	0	0	0	178	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(2,825)	0	5,700	0	2,875	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	14,200	0	0	0	0	0	0	0	0	14,200	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	Nurse Aide 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	14,200	0	14,200	16							
	C. General Administration													
17	Administrative	0	0	(56,995)	0	0	0	0	0	0	0	0	(56,995)	17
18	Directors Fees	0	0	11,249	0	0	0	0	0	0	0	0	11,249	18
19	Professional Services	0	0	13,426	0	0	0	0	0	0	0	0	13,426	19
20	Fees, Subscriptions & Promotions	0	(35)	2,902	0	0	0	0	0	0	0	0	2,867	20
21	Clerical & General Office Expenses	0	77	0	0	0	0	0	0	0	0	0	77	21
22	Employee Benefits & Payroll Taxes	0	0	61,873	0	0	0	0	0	0	0	0	61,873	22
23	Inservice Training & Education	0	0	15,979	0	0	0	0	0	0	0	0	15,979	23
24	Travel and Seminar	0	0	1,332	0	0	0	0	0	0	0	0	1,332	24
25	Other Admin. Staff Transportation	0	0	277	0	0	0	0	0	0	0	0	277	25
26	Insurance-Prop.Liab.Malpractice	0	0	2,108	0	0	0	0	0	0	0	0	2,108	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	0	42	52,151	0	52,193	28							
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(2,825)	42	72,051	0	69,268	29							

STATE OF ILLINOIS

Summary B

Facility Name & ID Number LAKEVIEW LIVING CENTER

0028134

Report Period Beginning:

07/01/2003

Ending:

06/30/2004

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)
	D. Ownership												
30	Depreciation	0	0	7,044	0	0	0	0	0	0	0	0	7,044 30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0 31
32	Interest	(20,798)	(4,890)	(4,993)	0	0	0	0	0	0	0	0	(30,681) 32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0 33
34	Rent-Facility & Grounds	0	0	11,847	0	0	0	0	0	0	0	0	11,847 34
35	Rent-Equipment & Vehicles	0	0	448	0	0	0	0	0	0	0	0	448 35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0 36
37	TOTAL Ownership	(20,798)	(4,890)	14,346	0	(11,342) 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):*	(1,577,806)	0	3,641	0	0	0	0	0	0	0	0	(1,574,165) 43
44	TOTAL Special Cost Centers	(1,577,806)	0	3,641	0	(1,574,165) 44							
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(1,601,429)	(4,848)	90,038	0	(1,516,239) 45							

Facility Name & ID Number LAKEVIEW LIVING CENTER

0028134

Report Period Beginning: 07/01/2003 Ending: 06/30/2004

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
RESIDENTIAL CENTERS, INC.	100	SEE ATTACHED RELATED PARTY SCHEDULE		SEE ATTACHED RELATED PARTY SCHEDULE		
SEE ATTACHED SCHEDULE 7A						

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	18 BOARD FEES	\$ 14,425	RESIDENTIAL CENTERS	100.00%	\$ 14,425	\$
2	V	19 PROFESSIONAL FEES	46,635	RESIDENTIAL CENTERS	100.00%	46,635	
3	V	20 LICENSE DUES	29	RESIDENTIAL CENTERS	100.00%	(6)	(35)
4	V	21 OFFICE SUPPLIES	29,490	RESIDENTIAL CENTERS	100.00%	29,567	77
5	V	22 INSERVICE TRAVEL	964	RESIDENTIAL CENTERS	100.00%	964	
6	V	32 INTEREST EXPENSE	45,089	RESIDENTIAL CENTERS	100.00%	45,746	657
7	V	32 MISCELLANEOUS INCOME		RESIDENTIAL CENTERS	100.00%	(1,749)	(1,749)
8	V	32 INTEREST INCOME		RESIDENTIAL CENTERS	100.00%	(3,798)	(3,798)
9	V	43 NONALLOW	112	RESIDENTIAL CENTERS	100.00%	112	
10	V						
11	V						
12	V						
13	V						
14	Total		\$ 136,744			\$ 131,896	\$ * (4,848)

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

Facility Name & ID Number LAKEVIEW LIVING CENTER

0028134

Report Period Beginning: 07/01/2003

Ending: 06/30/2004

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 ADMINISTRATIVE COST	\$ 368,629	CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	\$ 311,634	\$ (56,995)
16	V	18 DIRECTORS FEES		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	11,249	11,249
17	V	19 PROFESSIONAL FEES		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	13,426	13,426
18	V	20 DUES, FEES		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	2,902	2,902
19	V	22 EMPLOYEE BENEFITS		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	61,873	61,873
20	V	23 INSERVICE EDUCATION		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	15,979	15,979
21	V	24 TRAVEL SEMINAR		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	1,332	1,332
22	V	25 OTHER STAFF TRANSPORTATION		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	277	277
23	V	26 INSURANCE		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	2,108	2,108
24	V	30 DEPRECIATION		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	7,044	7,044
25	V	32 INTEREST		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	763	763
26	V	34 RENT		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	11,847	11,847
27	V	35 EQUIPMENT RENTAL		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	448	448
28	V	5 UTILITIES		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	2,197	2,197
29	V	6 MAINTENANCE		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	3,003	3,003
30	V	43 NONALLOWABLE		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	3,641	3,641
31	V	32 INTEREST INCOME		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	(5,140)	(5,140)
32	V	32 MISC INCOME		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	(616)	(616)
33	V	1 DIETARY		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	500	500
34	V	10 NURSING		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	14,200	14,200
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 368,629			\$ 458,667	\$ * 90,038

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

Facility Name & ID Number LAKEVIEW LIVING CENTER # 0028134 Report Period Beginning: 07/01/2003 Ending: 06/30/2004

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	RONALD SCHROEDER	CHAIRMAN	BOARD MEMBE	NONE	12,393	3HRS/MTG	2.00	DIR. FEES	\$ 3,607	L18, C8	1
2	SHAWN JEFFERS	VICE CHAIRMAN	BOARD MEMBE	NONE	11,594	3HRS/MTG	2.00	DIR. FEES	3,606	L18, C8	2
3	EDWARD CHILDERS	SECRETARY	BOARD MEMBE	NONE	12,394	3HRS/MTG	2.00	DIR. FEES	3,606	L18, C8	3
4	ROBERT BAUER	TREASURER	BOARD MEMBE	NONE	1,194	3HRS/MTG	2.00	DIR. FEES	3,606	L18, C8	4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 14,425		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 LIVING CENTER # 0028134 Report Period Beginning: 07/01/2003 Ending: 6/30/2004

VIII. ALLOCATION OF INDIRECT COSTS

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

Name of Related Organization RESIDENTIAL CENTERS, INC.
 Street Address 2020 W. WAR MEMORIAL DR. SUITE 103
 City / State / Zip Code PEORIA, IL. 616147
 Phone Number (309-685-0595
 Fax Number (309-685-8463

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

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	18	BOARD FEES	193	4	\$ 19,200	\$	145	\$ 14,425	1
2	19	PROFESSIONAL FEES	193	4	62,073		145	46,635	2
3	20	LICENSE DUES	193	4	(8)		145	(6)	3
4	21	OFFICE SUPPLIES	193	4	39,355		145	29,567	4
5	23	INSERVICE TRAVEL	193	4	1,283		145	964	5
6	32	INTEREST EXPENSE	193	4	60,889		145	45,746	6
7	32	MISCELLANEOUS INCOME	193	4	(2,328)		145	(1,749)	7
8	32	INTEREST INCOME	193	4	(5,056)		145	(3,798)	8
9	43	NONALLOW	193	4	150		145	112	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				\$ 175,558	\$		\$ 131,896	25

Facility Name & ID Number LAKEVIEW LIVING CENTER # 0028134 Report Period Beginning: 07/01/2003 Ending: 6/30/2004

VIII. ALLOCATION OF INDIRECT COSTS

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

Name of Related Organization CENTER FOR RESIDENTIAL MANAGEMENT
 Street Address 2020 W. WAR MEMORIAL DR. SUITE 103
 City / State / Zip Code PEORIA, IL. 616147
 Phone Number (309-685-0595)
 Fax Number (309-685-8463)

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

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6		
1	17	ADMINISTRATIVE COST	BEDS	330	18	\$ 699,564	\$ 574,949	145	\$ 307,384	1
2	18	DIRECTORS FEES	BEDS	330	18	25,600		145	11,249	2
3	19	PROFESSIONAL FEES	BEDS	330	18	30,555		145	13,426	3
4	20	DUES, FEES	BEDS	330	18	6,605		145	2,902	4
5	22	EMPLOYEE BENEFITS	BEDS	330	18	137,341		145	60,347	5
6	23	INSERVICE EDUCATION	BEDS	330	18	36,366		145	15,979	6
7	24	TRAVEL SEMINAR	BEDS	330	18	3,032		145	1,332	7
8	25	OTHER STAFF TRANSPORTATION	BEDS	330	18	631		145	277	8
9	26	INSURANCE	BEDS	330	18	4,797		145	2,108	9
10	30	DEPRECIATION	BEDS	330	18	16,031		145	7,044	10
11	32	INTEREST	BEDS	330	18	1,737		145	763	11
12	34	RENT	BEDS	330	18	26,963		145	11,847	12
13	35	EQUIPMENT RENTAL	BEDS	330	18	1,020		145	448	13
14	5	UTILITIES	BEDS	330	18	5,000		145	2,197	14
15	6	MAINTENANCE	BEDS	330	18	4,559		145	2,003	15
16	43	NONALLOWABLE	BEDS	330	18	8,286		145	3,641	16
17	32	MISC INCOME	BEDS	330	18	(1,401)		145	(616)	17
18	32	INTEREST INCOME	BEDS	330	18	(11,699)		145	(5,140)	18
19										19
20	17	ADMINISTRATIVE COST	DIRECT				4,250		4,250	20
21	1	DIETARY	DIRECT				500		500	21
22	10	NURSING	DIRECT				14,200		14,200	22
23	22	EMPLOYEE BENEFITS	DIRECT						1,526	23
24	6	MAINTENANCE	DIRECT				1,000		1,000	24
25	TOTALS					\$ 994,987	\$ 594,899		\$ 458,667	25

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			
A. Directly Facility Related																				
Long-Term																				
1	IL HEALTH FAC AUTH. BONDS	X	ACQUISITION OF FACILITI	ANNUAL PMT	12/01/92	\$ 6,160,000	\$ 2,522,000	08/15/16	8.5000	\$ 243,785	1									
2	PREMIER CAPITAL GROUP, INC.	X	LAUNDRY EQUIPMENT	\$175.00	10/05/99	6,942		10/05/04	17.5900	345	2									
3	EFFINGHAM STATE BANK		PURCHASE OF VEHICLES	\$1,083.74	06/24/02	23,986		05/30/04	8.1800	693	3									
4	EFFINGHAM STATE BANK	X	PURCHASE OF VEHICLES	\$1,086.42	06/18/03	24,502	12,617	06/18/05	6.3000	1,152	4									
5	GMAC	X	PURCHASE OF VEHICLES	\$721.51	07/02/01	24,960	4,730	01/02/05	10.9900	738	5									
Working Capital																				
6	ALLOCATED FROM PARENT CO.									54,205	6									
7	OFFSET INTERST INCOME/ NONALLOWABLE INT.									(32,101)	7									
8	MISCELLANEOUS INTEREST									3,237	8									
9	TOTAL Facility Related			\$3,066.67		\$ 6,240,390	\$ 2,539,347			\$ 272,054	9									
B. Non-Facility Related*																				
10											10									
11											11									
12											12									
13											13									
14	TOTAL Non-Facility Related					\$	\$			\$	14									
15	TOTALS (line 9+line14)					\$ 6,240,390	\$ 2,539,347			\$ 272,054	15									

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

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

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

Facility Name & ID Number LAKEVIEW LIVING CENTER

0028134 Report Period Beginning: 07/01/2003 Ending: 06/30/2004

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

B. Real Estate Taxes

		Important , please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.			
1.	Real Estate Tax accrual used on 2003 report.			\$	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.)			\$	2
3.	Under or (over) accrual (line 2 minus line 1).			\$	3
4.	Real Estate Tax accrual used for 2004 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	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.			\$	7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:		1999	N/A	8	
		2000		9	
		2001		10	
		2002		11	
		2003		12	
FOR OHF USE ONLY					
13	FROM R. E. TAX STATEMENT FOR 2003	\$			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.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2003 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2003 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2003.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2003 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2004 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2003 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME LAKEVIEW LIVING CENTER COUNTY COOK

FACILITY IDPH LICENSE NUMBER 0028134

CONTACT PERSON REGARDING THIS REPORT N/A

TELEPHONE () _____ FAX #: () _____

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2003 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 2003.

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

B. Real Estate Tax Cost Allocations

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

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

C. Tax Bills

Attach a copy of the original 2003 tax bills which were listed in Section A to this statement. Be sure to use the 2003 tax bill which is normally paid during 2004.

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 36,760 B. General Construction Type: Exterior BRICK Frame WOOD Number of Stories SIX

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, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

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: N/A 2. Number of Years Over Which it is Being Amortized: N/A
3. Current Period Amortization: N/A 4. Dates Incurred: N/A

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

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>RESIDENT</u>	<u>26,080</u>	<u>1988</u>	<u>\$ 41,516</u>	<u>1</u>
2					<u>2</u>
3	TOTALS	26,080		\$ 41,516	3

Facility Name & ID Number LAKEVIEW LIVING CENTER

0028134

Report Period Beginning:

07/01/2003

Ending:

06/30/2004

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 OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	145	1988	1910	\$ 1,585,984	\$ 45,314	35	\$ 45,314	\$	\$ 706,038	4
5										5
6										6
7										7
8										8
	Improvement Type**									
9	BUILDING IMPROVEMENT		1983	5,047		10			5,047	9
10	BUILDING IMPROVEMENT		1984	42,110		15			42,110	10
11	BUILDING IMPROVEMENT		1985	102,043		10			102,043	11
12	BUILDING IMPROVEMENT		1986	23,799		20			23,799	12
13	BUILDING IMPROVEMENT		1987	30,173		20			30,173	13
14	BUILDING IMPROVEMENT		1990	94,921		15			94,921	14
15	BUILDING IMPROVEMENT		1991	700		10			700	15
16	BUILDING IMPROVEMENT		1992	9,135	609	15	609		6,877	16
17	BUILDING IMPROVEMENT		1993	112,022	7,468	15	7,468		84,328	17
18	BUILDING IMPROVEMENT		1993	115,471	7,698	15	7,698		80,830	18
19	BUILDING IMPROVEMENT		1994			10				19
20	BUILDING IMPROVEMENT		1995	32,918	2,195	15	2,195		20,425	20
21	PHONE SYSTEM		1996	23,095	2,117	10	2,117		19,246	21
22	INSTALL FIRE HOUSE		1995	1,228	82	15	82		703	22
23	ELEVATOR IMPROVEMENTS		1996	3,356	224	15	224		1,865	23
24	RECEPTION AREA		1996	1,598	106	15	106		878	24
25	TWO SETS OF STEEL DOORS		1995	3,250	217	15	217		1,878	25
26	CABINETS IN RECEPTION AREA		1995	3,500	233	15	233		2,003	26
27	MOTOR FOR ELEVATOR		1996	2,042	136	15	136		1,078	27
28	TUB RESURFACING		1996	4,900	327	15	327		2,559	28
29	CONCRETE RAMP		1996	700	46	15	46		362	29
30	ROOF SHAFT & EXHAUST		1996	1,110	74	15	74		573	30
31	FLOOR DRAIN		1997	2,300	153	15	153		1,124	31
32	BOX ELEVATOR		1997	1,950	130	15	130		932	32
33	CONCRETE LUNCH AREA		1997	4,313	287	15	287		2,060	33
34	ROOF WORK		1997	45,658	3,044	15	3,044		21,815	34
35	BOX ON ELEVATOR		1998	525	35	15	35		242	35
36										36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number LAKEVIEW LIVING CENTER

0028134

Report Period Beginning:

07/01/2003 Ending: 06/30/2004

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		
37	LIGHTING	1998	\$ 2,715	\$ 181	15	\$ 181	\$	\$ 1,222		37
38	PLUMBING	1998	700	47	15	47		304		38
39	SPRINKLER SYSTEM	1998	2,531	169	15	169		1,148		39
40	ROOF TOP EXHAUST FAN	1998	635	42	15	42		278		40
41	ELECTRIC DOOR STRIKE	1998	582	39	15	39		269		41
42	GLASS	1998	679	45	15	45		309		42
43	CARPET	1999	518	34	15	34		186		43
44	DOOR	1999	680	45	15	45		211		44
45	BATHROOM RENOVATIONS	2000	8,800	587	15	587		2,090		45
46	PLUMBING	2001	2,100	140	15	140		443		46
47	SHOWER BASE AND TILES	2001	2,200	147	15	147		440		47
48	TUCK POINTING BRICK	2001	43,284	2,886	15	2,886		7,936		48
49	STEEL DOORS	2002	1,430	95	15	95		230		49
50	RESURFACE BATHTUB	2002	1,120	75	15	75		175		50
51	WATER LINE MOTOR	2002	1,275	85	15	85		191		51
52	ELEVATOR EDGE	2001	1,696	113	15	113		330		52
53	ELEVATOR DOORS	2002	920	61	15	61		148		53
54	WATER LINE	2002	1,750	117	15	117		243		54
55	PHONE SYSTEM DISPOSAL	2004	(23,095)		10			(19,246)		55
56	HOPKINS ELEVATOR REPAIR	2004	1,009	45	15	45		45		56
57	DURAGLAZE TUB REFURNISHING	2004	2,845	32	15	32		32		57
58										58
59										59
60										60
61										61
62										62
63										63
64										64
65										65
66										66
67										67
68										68
69										69
70	TOTAL (lines 4 thru 69)		\$ 2,308,222	\$ 75,480		\$ 75,480	\$	\$ 1,251,593		70

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

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	\$ 459,302	\$ 43,414	\$ 43,414	\$	5-10 YRS	\$ 244,740	71
72	Current Year Purchases	84,947	3,974	3,974		5-10 YRS	3,974	72
73	Fully Depreciated Assets	505,868					504,977	73
74	PARENT COMPANY ALLOCATION		7,044	7,044				74
75	TOTALS	\$ 1,050,117	\$ 54,432	\$ 54,432	\$		\$ 753,691	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	RESIDENT TRANSPORTATION	85 DODGE VAN	2002	\$ 2,800	\$ 560	\$ 560	\$	5	\$ 1,400	76
77	RESIDENT TRANSPORTATION	2002 FORD VAN	2002	23,986	4,797	4,797		5	9,994	77
78	RESIDENT TRANSPORTATION	2003 FORD VAN	2003	24,502	4,901	4,901		5	5,309	78
79	RESIDENT TRANSPORTATION	2-2001 CHEVY LUMINAS	2001	24,960	3,744	3,744		5	14,976	79
80	TOTALS			\$ 76,248	\$ 14,002	\$ 14,002	\$		\$ 31,679	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)	\$ 3,476,103	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 143,914	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 143,914	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 2,036,963	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.

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

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

<p>1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? <input checked="" type="checkbox"/> YES <input 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. CLASSROOM PORTION:</p> <p>IN-HOUSE PROGRAM <input checked="" type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER AIDE <u>40</u></p>	<p>3. CLINICAL PORTION:</p> <p>IN-HOUSE PROGRAM <input checked="" type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER AIDE <u>80</u></p>
-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	---------------------------------------------------------------------------------------------------------------------------------------------------------------------------

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility			
		1	2	3	4
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies		500		500
3	Classroom Wages (a)		8,350		8,350
4	Clinical Wages (b)		13,360		13,360
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	\$	22,210	\$	22,210
10	SUM OF line 9, col. 1 and 2 (e)	\$	22,210		

C. CONTRACTUAL INCOME

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

\$ 22,445

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	20
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	20

- (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 aide 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 aides.

- (e) The total amount of Drop-out and Completed Costs for your own aides 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 aides.

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

	Service	Schedule V Line & Column Reference	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		hrs	\$		\$	\$		\$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): ER DENTAL				1	550		1	550	13
14	TOTAL			\$	1	\$ 550	\$	1	\$ 550	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 nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number LAKEVIEW LIVING CENTER

STATE OF ILLINOIS

0028134

Report Period Beginning: 07/01/2003

Ending:

06/30/2004

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 06/30/2004

(last day of reporting year)

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

	1	2	
	Operating	After Consolidation*	
A. Current Assets			
1	Cash on Hand and in Banks	\$ 7,382	1
2	Cash-Patient Deposits	62,681	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 92,396)	620,644	3
4	Supply Inventory (priced at)		4
5	Short-Term Investments		5
6	Prepaid Insurance	9,640	6
7	Other Prepaid Expenses	27,571	7
8	Accounts Receivable (owners or related parties)	4,978,522	8
9	Other(specify):		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 5,706,440	10
B. Long-Term Assets			
11	Long-Term Notes Receivable		11
12	Long-Term Investments		12
13	Land	41,516	13
14	Buildings, at Historical Cost	2,308,222	14
15	Leasehold Improvements, at Historical Cost		15
16	Equipment, at Historical Cost	1,126,365	16
17	Accumulated Depreciation (book methods)	(2,036,963)	17
18	Deferred Charges		18
19	Organization & Pre-Operating Costs		19
20	Accumulated Amortization - Organization & Pre-Operating Costs		20
21	Restricted Funds	531,655	21
22	Other Long-Term Assets (specify):		22
23	Other(specify): LOAN COST	138,028	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 2,108,823	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 7,815,263	25

	1	2	
	Operating	After Consolidation*	
C. Current Liabilities			
26	Accounts Payable	\$ 544,912	26
27	Officer's Accounts Payable		27
28	Accounts Payable-Patient Deposits	62,681	28
29	Short-Term Notes Payable		29
30	Accrued Salaries Payable	157,328	30
31	Accrued Taxes Payable (excluding real estate taxes)	10,397	31
32	Accrued Real Estate Taxes(Sch.IX-B)		32
33	Accrued Interest Payable	107,185	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)	\$ 882,503	38
D. Long-Term Liabilities			
39	Long-Term Notes Payable	102,872	39
40	Mortgage Payable		40
41	Bonds Payable	2,522,000	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)	\$ 2,624,872	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 3,507,375	46
47	TOTAL EQUITY(page 18, line 24)	\$ 4,307,888	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 7,815,263	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 3,895,334	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 3,895,334	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	412,554	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)	\$ 412,554	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)	\$ 4,307,888	24 *

* This must agree with page 17, line 47.

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

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

		1	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 6,059,436	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 6,059,436	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	8
C. Other Operating Revenue			
9	Payments for Education	1,532,117	9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements	22,445	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	2,825	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)	\$ 1,557,387	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	17,561	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 17,561	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 7,634,384	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	875,776	31
32	Health Care	2,584,662	32
33	General Administration	1,379,474	33
B. Capital Expense			
34	Ownership	456,465	34
C. Ancillary Expense			
35	Special Cost Centers	1,574,165	35
36	Provider Participation Fee	351,288	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 7,221,830	40
41	Income before Income Taxes (line 30 minus line 40)**	412,554	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 412,554	43

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? NO If not, please attach a reconciliation.

*** 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 LIVING CENTER

0028134

Report Period Beginning: 07/01/2003

Ending:

06/30/2004

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

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	1,965	2,095	\$ 53,432	\$ 25.50	1
2	Assistant Director of Nursing	2,302	2,546	47,690	18.73	2
3	Registered Nurses					3
4	Licensed Practical Nurses	15,878	17,183	319,223	18.58	4
5	Nurse Aides & Orderlies					5
6	Nurse Aide Trainees	2,600	2,600	21,710	8.35	6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants					10
11	Social Service Workers	2,168	2,401	23,060	9.60	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	22,119	23,897	216,404	9.06	15
16	Dishwashers					16
17	Maintenance Workers	5,773	6,182	78,924	12.77	17
18	Housekeepers	9,689	10,638	86,767	8.16	18
19	Laundry	4,648	5,112	50,928	9.96	19
20	Administrator	2,055	2,133	67,645	31.71	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	9,056	9,805	107,218	10.94	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)	15,505	16,268	242,293	14.89	28
29	Resident Services Coordinator	3,919	4,221	81,572	19.33	29
30	Habilitation Aides (DD Homes)	160,020	174,080	1,591,858	9.14	30
31	Medical Records	2,292	2,471	18,580	7.52	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	259,989	281,632	\$ 3,007,304 *	\$ 10.68	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	261	\$ 12,082	L1, C3	35
36	Medical Director				36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant	105	6,118	L10A, C3	40
41	Occupational Therapy Consultant	110	5,693	L10A, C3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	312	12,480	L10A, C3	43
44	Activity Consultant				44
45	Social Service Consultant	625	32,713	L12, C3	45
46	Other(specify)				46
47	PSYCHOLOGICAL	MONTHLY	50,952	L10, C3	47
48					48
49	TOTAL (lines 35 - 48)	1,413	\$ 120,038		49

C. CONTRACT NURSES

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

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. ILLINOIS HEALTH CARE ASSOC. \$7830
- (3) Did the nursing home make political contributions or payments to a political action organization? NO If YES, have these costs been properly adjusted out of the cost report? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? YES
What was the average life used for new equipment added during this period? 10 YRS
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 0 Line 10
- (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 of Public Aid during this cost report period. \$ 351,288
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 of Public Aid, 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. \$ 47,779 Has any meal income been offset against related costs? NA 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? 80
d. Have vehicle usage logs been maintained? ADEQUATE RECORDS ARE MAINTAINED
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? YES
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? YES
Firm Name: HEINOLD - BANWART, LTD. The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? YES If no, please explain.
- (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 \$2500, 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.