

Facility Name & ID Number LAKEVIEW LIVING CENTER

0028134 Report Period Beginning: 07/01/2004 Ending: 06/30/2005

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	<u>145</u>	Intermediate/DD	<u>145</u>	<u>52,925</u>	4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>145</u>	TOTALS	<u>145</u>	<u>52,925</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment			5 Total	
		3 Medicaid Recipient	4 Private Pay	Other		
8	SNF					8
9	SNF/PED					9
10	ICF					10
11	ICF/DD	<u>45,445</u>	<u>365</u>		<u>45,810</u>	11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>45,445</u>	<u>365</u>		<u>45,810</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 86.56%

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

1,061 (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 05/23/1983

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

YES Date 12/01/1988 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: 06/30/2005 Fiscal Year: 06/30/2005

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

Facility Name & ID Number

LAKEVIEW LIVING CENTER

0028134

Report Period Beginning:

07/01/2004

Ending:

06/30/2005

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	229,731	27,098	14,469	271,298		271,298		271,298		1
2	Food Purchase		172,528		172,528		172,528		172,528		2
3	Housekeeping	105,215	25,874		131,089		131,089	167	131,256		3
4	Laundry	47,617	21,347	1,422	70,386		70,386		70,386		4
5	Heat and Other Utilities			123,910	123,910		123,910	4,924	128,834		5
6	Maintenance	82,902		42,855	125,757		125,757	2,464	128,221		6
7	Other (specify):*										7
8	TOTAL General Services	465,465	246,847	182,656	894,968		894,968	7,555	902,523		8
	B. Health Care and Programs										
9	Medical Director										9
10	Nursing and Medical Records	2,473,689	17,078	78,976	2,569,743		2,569,743		2,569,743		10
10a	Therapy			25,794	25,794		25,794		25,794		10a
11	Activities		33,688		33,688		33,688		33,688		11
12	Social Services	20,080		36,918	56,998		56,998		56,998		12
13	CNA Training	14,742	325		15,067		15,067		15,067		13
14	Program Transportation			17,202	17,202		17,202		17,202		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	2,508,511	51,091	158,890	2,718,492		2,718,492		2,718,492		16
	C. General Administration										
17	Administrative	67,016		413,526	480,542		480,542	(84,811)	395,731		17
18	Directors Fees			12,021	12,021		12,021	12,693	24,714		18
19	Professional Services			50,281	50,281		50,281	8,774	59,055		19
20	Dues, Fees, Subscriptions & Promotions			12,828	12,828		12,828	2,873	15,701		20
21	Clerical & General Office Expenses	106,782	13,563	33,424	153,769		153,769		153,769		21
22	Employee Benefits & Payroll Taxes			443,854	443,854		443,854	47,798	491,652		22
23	Inservice Training & Education			20,473	20,473		20,473	17,589	38,062		23
24	Travel and Seminar			4,045	4,045		4,045	18,603	22,648		24
25	Other Admin. Staff Transportation			2,450	2,450		2,450		2,450		25
26	Insurance-Prop.Liab.Malpractice			33,072	33,072		33,072	7,496	40,568		26
27	Other (specify):*										27
28	TOTAL General Administration	173,798	13,563	1,025,974	1,213,335		1,213,335	31,015	1,244,350		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,147,774	311,501	1,367,520	4,826,795		4,826,795	38,570	4,865,365		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:

07/01/2004

Ending:

06/30/2005

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			143,245	143,245		143,245	14,345	157,590			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			298,286	298,286		298,286	(17,483)	280,803			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds							12,097	12,097			34
35	Rent-Equipment & Vehicles			16,859	16,859		16,859	480	17,339			35
36	Other (specify):*											36
37	TOTAL Ownership			458,390	458,390		458,390	9,439	467,829			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			363,568	363,568		363,568		363,568			42
43	Other (specify):*			1,486,530	1,486,530		1,486,530	(1,486,530)				43
44	TOTAL Special Cost Centers			1,850,098	1,850,098		1,850,098	(1,486,530)	363,568			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,147,774	311,501	3,676,008	7,135,283		7,135,283	(1,438,521)	5,696,762			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: 07/01/2004

Ending: 06/30/2005

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	(1,485,621)	43		3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space	(1,690)	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	(14,911)	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	(2,186)	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees	(3,812)	43		17
18	Fines and Penalties	(70)	43		18
19	Entertainment				19
20	Contributions	(225)	32		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	(841)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (1,509,356)		\$	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)	70,835		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 70,835		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (1,438,521)		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: 07/01/2004

Ending: 06/30/2005

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
1		\$	1
2			2
3			3
4			4
5			5
6			6
7			7
8			8
9			9
10			10
11			11
12			12
13			13
14			14
15			15
16			16
17			17
18			18
19			19
20			20
21			21
22			22
23			23
24			24
25			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:

07/01/2004 Ending: 06/30/2005

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	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	167	0	0	0	0	0	0	0	0	167	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	4,924	0	0	0	0	0	0	0	0	4,924	5
6	Maintenance	(1,690)	0	4,154	0	0	0	0	0	0	0	0	2,464	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(1,690)	0	9,245	0	7,555	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	(84,811)	0	0	0	0	0	0	0	0	(84,811)	17
18	Directors Fees	0	0	12,693	0	0	0	0	0	0	0	0	12,693	18
19	Professional Services	0	0	8,774	0	0	0	0	0	0	0	0	8,774	19
20	Fees, Subscriptions & Promotions	0	0	2,873	0	0	0	0	0	0	0	0	2,873	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	0	0	47,798	0	0	0	0	0	0	0	0	47,798	22
23	Inservice Training & Education	0	0	17,589	0	0	0	0	0	0	0	0	17,589	23
24	Travel and Seminar	0	0	18,603	0	0	0	0	0	0	0	0	18,603	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	7,496	0	0	0	0	0	0	0	0	7,496	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	0	0	31,015	0	31,015	28							
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(1,690)	0	40,260	0	38,570	29							

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. SEE ATTACHED SCHEDULE 7A	100	SEE ATTACHED RELATED PARTY SCHEDULE		SEE ATTACHED RELATED PARTY SCHEDULE		

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	18 BOARD FEES	\$ 12,021	RESIDENTIAL CENTERS	100.00%	\$ 12,021	\$	1
2	V	19 PROFESSIONAL FEES	40,868	RESIDENTIAL CENTERS	100.00%	40,868		2
3	V	20 LICENSE DUES	15	RESIDENTIAL CENTERS	100.00%	15		3
4	V	21 OFFICE SUPPLIES	11,050	RESIDENTIAL CENTERS	100.00%	11,050		4
5	V	22 INSERVICE TRAVEL	790	RESIDENTIAL CENTERS	100.00%	790		5
6	V	32 INTEREST EXPENSE	51,694	RESIDENTIAL CENTERS	100.00%	51,694		6
7	V	22 EMPLOYEE BENEFITS	37	RESIDENTIAL CENTERS	100.00%	37		7
8	V	32 INTEREST INCOME	(8,595)	RESIDENTIAL CENTERS	100.00%	(8,595)		8
9	V	43 NONALLOW	19	RESIDENTIAL CENTERS	100.00%	19		9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 107,899			\$ 107,899	\$ *	14

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

Facility Name & ID Number LAKEVIEW LIVING CENTER

0028134

Report Period Beginning: 07/01/2004 Ending: 06/30/2005

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	\$ 413,526	CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	\$ 328,715	\$ (84,811)
16	V	18 DIRECTORS FEES		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	12,693	12,693
17	V	19 PROFESSIONAL FEES		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	8,774	8,774
18	V	20 DUES, FEES		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	2,873	2,873
19	V	22 EMPLOYEE BENEFITS		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	47,798	47,798
20	V	23 INSERVICE EDUCATION		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	17,589	17,589
21	V	24 TRAVEL SEMINAR		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	18,603	18,603
22	V	26 INSURANCE		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	7,496	7,496
23	V	30 DEPRECIATION		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	14,345	14,345
24	V	32 INTEREST		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	848	848
25	V	34 RENT		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	12,097	12,097
26	V	35 EQUIPMENT RENTAL		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	480	480
27	V	5 UTILITIES		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	4,924	4,924
28	V	6 MAINTENANCE		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	4,154	4,154
29	V	43 NONALLOWABLE		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	3,814	3,814
30	V	32 INTEREST INCOME		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	(552)	(552)
31	V	32 MISC INCOME		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	(457)	(457)
32	V	3 HOUSEKEEPING		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	167	167
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 413,526			\$ 484,361	\$ * 70,835

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

Facility Name & ID Number LAKEVIEW LIVING CENTER # 0028134 Report Period Beginning: 07/01/2004 Ending: 06/30/2005

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	12,195	3HRS/MTG	1.00	DIR. FEES	\$ 3,005	L18, C8	1
2	SHAWN JEFFERS	VICE CHAIRMAN	BOARD MEMBE	NONE	12,195	3HRS/MTG	1.00	DIR. FEES	3,005	L18, C8	2
3	EDWARD CHILDERS	SECRETARY	BOARD MEMBE	NONE	12,194	3HRS/MTG	1.00	DIR. FEES	3,006	L18, C8	3
4	ROBERT BAUER	TREASURER	BOARD MEMBE	NONE	995	3HRS/MTG	1.00	DIR. FEES	3,005	L18, C8	4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 12,021		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: 07/01/2004 Ending: 6/30/2005

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	\$ 16,000	\$	145	\$ 12,021	1
2	19	PROFESSIONAL FEES	193	4	54,397		145	40,868	2
3	20	LICENSE DUES	193	4	20		145	15	3
4	21	OFFICE SUPPLIES	193	4	14,708		145	11,050	4
5	22	INSERVICE TRAVEL	193	4	1,052		145	790	5
6	32	INTEREST EXPENSE	193	4	68,806		145	51,694	6
7	22	EMPLOYEE BENEFITS	193	4	49		145	37	7
8	32	INTEREST INCOME	193	4	(11,440)		145	(8,595)	8
9	43	NONALLOW	193	4	25		145	19	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				\$ 143,617	\$		\$ 107,899	25

Facility Name & ID Number LAKEVIEW LIVING CENTER # 0028134 Report Period Beginning: 07/01/2004 Ending: 6/30/2005

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	329	16	\$ 745,843	\$ 627,510	145	\$ 328,715	1
2	18	DIRECTORS FEES	329	16	28,800		145	12,693	2
3	19	PROFESSIONAL FEES	329	16	19,908		145	8,774	3
4	20	DUES, FEES	329	16	6,518		145	2,873	4
5	22	EMPLOYEE BENEFITS	329	16	108,451		145	47,798	5
6	23	INSERVICE EDUCAQTION	329	16	39,909		145	17,589	6
7	24	TRAVEL SEMINAR	329	16	42,209		145	18,603	7
8	26	INSURANCE	329	16	17,009		145	7,496	8
9	30	DEPRECIATION	329	16	32,549		145	14,345	9
10	32	INTEREST	329	16	1,924		145	848	10
11	34	RENT	329	16	27,449		145	12,097	11
12	35	EQUIPMENT RENTAL	329	16	1,088		145	480	12
13	5	UTILITIES	329	16	11,172		145	4,924	13
14	6	MAINTENANCE	329	16	9,426		145	4,154	14
15	43	NONALLOWABLE	329	16	8,653		145	3,814	15
16	32	INTEREST INCOME	329	16	(1,252)		145	(552)	16
17	32	MISC INCOME	329	16	(1,036)		145	(457)	17
18	3	HOUSEKEEPING	329	16	379		145	167	18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 1,098,999	\$ 627,510		\$ 484,361	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	\$ 2,423,200	08/15/16	8.5000	\$ 215,264	1									
2											2									
3	BANTERRA BANK	X	PURCHASE OF VEHICLES	\$328.14	07/15/04	16,631	13,976	07/15/09	6.7500	955	3									
4	EFFINGHAM STATE BANK	X	PURCHASE OF VEHICLES	\$1,086.42	06/18/03	24,502		06/18/05	6.3000	541	4									
5											5									
	Working Capital																			
6	HEALTHCARE BUSINESS CREDIT	X	WORKING CAPITAL		5/12/2003	700,000	701,110		10.5000	78,880	6									
7			OFFSET INTERST INCOME/ NONALLOWABLE INT.							(15,685)	7									
8										848	8									
9	TOTAL Facility Related			\$1,414.56		\$ 6,901,133	\$ 3,138,286			\$ 280,803	9									
	B. Non-Facility Related*																			
10											10									
11											11									
12											12									
13											13									
14	TOTAL Non-Facility Related					\$	\$			\$	14									
15	TOTALS (line 9+line14)					\$ 6,901,133	\$ 3,138,286			\$ 280,803	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: 07/01/2004 Ending: 06/30/2005

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2004 report.		Important , please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	\$	N/A	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).			\$	#VALUE!	3
4. Real Estate Tax accrual used for 2005 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.			\$	#VALUE!	7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:		2000 _____ 8			
		2001 _____ 9			
		2002 _____ 10			
		2003 _____ 11			
		2004 _____ 12			
			FOR OHF USE ONLY		
			13	FROM R. E. TAX STATEMENT FOR 2004 \$	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:** 2004 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 2004 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2004.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2004 real estate tax bill to the Department of Public Aid, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2005 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2004 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 2004 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 2004.

(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 2004 tax bills which were listed in Section A to this statement. Be sure to use the 2004 tax bill which is normally paid during 2005.

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 36,790 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, CNA 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	RESIDENT CARE	26,080	1988	\$ 41,516	1
2					2
3	TOTALS	26,080		\$ 41,516	3

Facility Name & ID Number LAKEVIEW LIVING CENTER

0028134

Report Period Beginning:

07/01/2004 Ending: 06/30/2005

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

1	2	3	4	5	6	7	8	9		
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	145	1988	1910	\$ 1,585,984	\$ 45,314	35	\$ 45,314	\$	\$ 751,352	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		7,486	16
17	BUILDING IMPROVEMENT		1993	112,022	7,468	15	7,468		91,796	17
18	BUILDING IMPROVEMENT		1993	115,471	7,698	15	7,698		88,528	18
19	BUILDING IMPROVEMENT		1994			10				19
20	BUILDING IMPROVEMENT		1995	32,918	2,195	15	2,195		22,620	20
21	INSTALL FIRE HOUSE		1995	1,228	82	15	82		785	21
22	ELEVATOR IMPROVEMENTS		1996	3,356	224	15	224		2,089	22
23	RECEPTION AREA		1996	1,598	107	15	107		985	23
24	TWO SETS OF STEEL DOORS		1995	3,250	217	15	217		2,094	24
25	CABINETS IN RECEPTION AREA		1995	3,500	233	15	233		2,236	25
26	MOTOR FOR ELEVATOR		1996	2,042	136	15	136		1,214	26
27	TUB RESURFACING		1996	4,900	327	15	327		2,886	27
28	CONCRETE RAMP		1996	700	46	15	46		408	28
29	ROOF SHAFT & EXHAUST		1996	1,110	74	15	74		647	29
30	FLOOR DRAIN		1997	2,300	153	15	153		1,278	30
31	BOX ELEVATOR		1997	1,950	130	15	130		1,062	31
32	CONCRETE LUNCH AREA		1997	4,313	286	15	286		2,347	32
33	ROOF WORK		1997	45,658	3,044	15	3,044		24,858	33
34	BOX ON ELEVATOR		1998	525	35	15	35		277	34
35	LIGHTING		1998	2,715	181	15	181		1,403	35
36	PLUMBING		1998	700	47	15	47		350	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:

07/01/2004 Ending: 06/30/2005

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	SPRINKLER SYSTEM	1998	\$ 2,531	\$ 169	15	\$ 169		\$ 1,317	37
38	ROOF TOP EXHAUST FAN	1998	635	42	15	42		321	38
39	ELECTRIC DOOR STRIKE	1998	582	39	15	39		307	39
40	GLASS	1998	679	45	15	45		355	40
41	CARPET	1999	518	35	15	35		221	41
42	DOOR	1999	680	45	15	45		257	42
43	BATHROOM RENOVATIONS	2000	8,800	587	15	587		2,677	43
44	PLUMBING	2001	2,100	140	15	140		583	44
45	SHOWER BASE AND TILES	2001	2,200	147	15	147		587	45
46	TUCK POINTING BRICK	2001	43,284	2,886	15	2,886		10,821	46
47	STEEL DOORS	2002	1,430	95	15	95		326	47
48	RESURFACE BATHTUB	2002	1,120	75	15	75		249	48
49	WATER LINE MOTOR	2002	1,275	85	15	85		276	49
50	ELEVATOR EDGE	2001	1,696	113	15	113		443	50
51	ELEVATOR DOORS	2002	920	61	15	61		210	51
52	WATER LINE	2002	1,750	117	15	117		360	52
53	HOPKINS ELEVATOR REPAIR	2004	1,009	67	15	67		112	53
54	DURAGLAZE TUB REFURNISHING	2004	2,845	190	15	190		221	54
55	ROOF REPAIRS	2004	1,050	70	15	70		70	55
56	FLOORING	2004	2,928	195	15	195		195	56
57	WINDOWS	2004	1,885	94	15	94		94	57
58	ELEVATOR REPAIRS	2004	1,480	74	15	74		74	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)		\$ 2,315,565	\$ 73,977		\$ 73,977		\$ 1,325,570	70

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

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	\$ 498,684	\$ 50,337	\$ 50,337	\$	5-10 YRS	\$ 253,154	71
72	Current Year Purchases	35,616	2,475	2,475		5-10 YRS	2,475	72
73	Fully Depreciated Assets	550,169					550,169	73
74								74
75	TOTALS	\$ 1,084,469	\$ 52,812	\$ 52,812	\$		\$ 805,798	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 TRANSPORTA	2002 FORD VAN	2002	\$ 23,986	\$ 4,797	\$ 4,797	\$	5	\$ 14,791	76
77	RESIDENT TRANSPORTA	2003 FORD VAN	2003	24,501	4,901	4,901		5	10,209	77
78	RESIDENT TRANSPORTA	2001 CHEVY LUMINA/85 DOD	2001	12,480	3,056	3,056		5	9,984	78
79	RESIDENT TRANSPORTA	2004 CHEVY VENTURE/85 DOI	2004	18,511	3,702	3,702		5	3,702	79
80	TOTALS			\$ 79,478	\$ 16,456	\$ 16,456	\$		\$ 38,686	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)	\$ 3,521,028	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 143,245	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 143,245	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)	\$ 2,170,054	85

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

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

G. Construction-in-Progress

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

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A
 2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
 If NO, see instructions. YES NO

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

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.	<u>/2006</u>	\$ _____
13.	<u>/2007</u>	\$ _____
14.	<u>/2008</u>	\$ _____

8. List separately any amortization of lease expense included on page 4, line 34.
 This amount was calculated by dividing the total amount to be amortized _____
 by the length of the lease _____.

9. Option to Buy: YES NO Terms: _____ *

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

15. Is Movable equipment rental included in building rental? YES NO
 16. Rental Amount for movable equipment: \$ _____ Description: COPIER \$14459, DISHWASHER \$2400, CORP. ALLOC \$480
 (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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

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

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

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

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?</p> <p><input 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 CNA <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 CNA <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		325		325
3	Classroom Wages (a)		4,914		4,914
4	Clinical Wages (b)		9,828		9,828
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$ 15,067	\$	\$ 15,067
10	SUM OF line 9, col. 1 and 2 (e)	\$	15,067		

C. CONTRACTUAL INCOME

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

\$ 19,452

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	13
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	13

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

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

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

	Service	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 prescripts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			\$		\$	\$		\$	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.

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	\$ 4,312	\$	1
2	Cash-Patient Deposits	74,883		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 90,850)	1,217,755		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	9,009		6
7	Other Prepaid Expenses	27,211		7
8	Accounts Receivable (owners or related parties)	4,648,428		8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 5,981,598	\$	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	1,585,984		14
15	Leasehold Improvements, at Historical Cost	729,581		15
16	Equipment, at Historical Cost	1,163,947		16
17	Accumulated Depreciation (book methods)	(2,170,054)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	537,461		21
22	Other Long-Term Assets (specify):			22
23	Other(specify): LOAN COST	102,599		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,991,034	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 7,972,632	\$	25

		1	2	
		Operating	After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 564,744	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	74,883		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	153,862		30
31	Accrued Taxes Payable (excluding real estate taxes)	10,007		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	102,986		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)	\$ 906,482	\$	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable	73,818		39
40	Mortgage Payable			40
41	Bonds Payable	2,423,200		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)	\$ 2,497,018	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 3,403,500	\$	46
47	TOTAL EQUITY (page 18, line 24)	\$ 4,569,132	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 7,972,632	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 4,304,707	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 4,304,707	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	264,425	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)	\$ 264,425	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)	\$ 4,569,132	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	\$ 5,877,809	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 5,877,809	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	1,485,621	9
10	Other Government Grants		10
11	CNA Training Reimbursements	19,452	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	1,690	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)	\$ 1,506,763	23
D. Non-Operating Revenue			
24	Contributions	225	24
25	Interest and Other Investment Income***	14,911	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 15,136	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)	\$ 7,399,708	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	894,968	31
32	Health Care	2,718,492	32
33	General Administration	1,213,335	33
B. Capital Expense			
34	Ownership	458,390	34
C. Ancillary Expense			
35	Special Cost Centers	1,486,530	35
36	Provider Participation Fee	363,568	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 7,135,283	40
41	Income before Income Taxes (line 30 minus line 40)**	264,425	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 264,425	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: 07/01/2004

Ending: 06/30/2005

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	1,931	2,118	\$ 54,000	\$ 25.50	1
2	Assistant Director of Nursing	2,150	2,381	44,920	18.87	2
3	Registered Nurses					3
4	Licensed Practical Nurses	15,578	17,015	327,676	19.26	4
5	CNAs & Orderlies					5
6	CNA Trainees	1,560	1,560	14,742	9.45	6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants					10
11	Social Service Workers	1,895	2,168	20,080	9.26	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	22,236	24,282	229,731	9.46	15
16	Dishwashers					16
17	Maintenance Workers	6,715	7,176	82,902	11.55	17
18	Housekeepers	11,130	12,031	105,215	8.75	18
19	Laundry	4,088	4,721	47,617	10.09	19
20	Administrator	1,945	2,046	67,016	32.75	20
21	Assistant Administrator					21
22	Other Administrative	8,956	9,737	106,782	10.97	22
23	Office Manager					23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)	17,538	18,227	270,423	14.84	28
29	Resident Services Coordinator	3,811	4,195	80,541	19.20	29
30	Habilitation Aides (DD Homes)	163,900	177,792	1,680,167	9.45	30
31	Medical Records	2,011	2,109	15,962	7.57	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	265,444	287,558	\$ 3,147,774 *	\$ 10.95	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	281	\$ 13,284	L1, C3	35
36	Medical Director				36
37	Medical Records Consultant				37
38	Nurse Consultant	113	2,831	L10, C3	38
39	Pharmacist Consultant	MONTHLY	1,584	L10, C3	39
40	Physical Therapy Consultant	113	6,300	L10A, C3	40
41	Occupational Therapy Consultant	108	6,034	L10A, C3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	337	13,460	L10A, C3	43
44	Activity Consultant				44
45	Social Service Consultant	708	36,918	L12, C3	45
46	Other(specify)				46
47	PSYCHOLOGICAL	MONTHLY	55,540	L10, C3	47
48					48
49	TOTAL (lines 35 - 48)	1,660	\$ 135,951		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	Certified Nurse Assistants/Aides			52
53	TOTAL (lines 50 - 52)	\$		53

A. Administrative Salaries	Name	Function	Ownership %	Amount
	JOHN MIRECKI	ADMINISTRATOR	0	\$ 67,016
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)				
				\$ 67,016

B. Administrative - Other	Description	Amount
	MANAGEMENT FEES ADJ ON SCHEDULE 6A	\$ 413,526
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)		
		\$ 413,526

C. Professional Services	Vendor/Payee	Type	Amount
	PERSONNEL PLANNERS, INC	U/C CONSULTATION	\$ 3,090
	LAWRENCE MANSON	LEGAL	23,905
	HBCC	ACCOUNTING	3,139
	HEINOLD-BANWART	ACCOUNTING	17,173
	WESTERVELT JOHNSON	LEGAL	245
	LAWRENCE MANSON	LEGAL	5,238
	HEINOLD-BANWART	ACCOUNTING	3,290
	JP MORGAN CHASE	TRUSTEE FEES	2,975
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$2500 attach copy of invoices.)			
			\$ 59,055

D. Employee Benefits and Payroll Taxes	Description	Amount
	Workers' Compensation Insurance	\$ (104,445)
	Unemployment Compensation Insurance	58,223
	FICA Taxes	258,431
	Employee Health Insurance	192,638
	Employee Meals	47,475
	Illinois Municipal Retirement Fund (IMRF)*	
	UNION PENSION FUND	33,929
	EMPLOYEE MORAL	5,401
TOTAL (agree to Schedule V, line 22, col.8)		
		\$ 491,652

E. Schedule of Non-Cash Compensation Paid to Owners or Employees	Description	Line #	Amount
	N/A		\$
TOTAL			
			\$

F. Dues, Fees, Subscriptions and Promotions	Description	Amount
	IDPH License Fee	\$ 943
	Advertising: Employee Recruitment	
	Health Care Worker Background Check (Indicate # of checks performed 131)	1,310
	ILLINOIS HEALTH CARE DUES	5,916
	VEHICLE LICENSE	364
	PARENT ALLOC	2,873
	CITY LICENSE/PERMITS	1,590
	MES/MAG. SUBSCRIPTIONS	2,705
	Less: Public Relations Expense	()
	Non-allowable advertising	()
	Yellow page advertising	()
TOTAL (agree to Sch. V, line 20, col. 8)		
		\$ 15,701

G. Schedule of Travel and Seminar**	Description	Amount
	Out-of-State Travel	\$
	In-State Travel	
	QMRP/IHCA CONV/BEST PRACTICES	2,191
	Seminar Expense	
	BASIL BEHAVOIR ANALYSIS	91
	MBA PROGRAM TUITION	18,515
	QMRP/IHCA CONV/BEST PRACTICES	1,851
	Entertainment Expense	()
TOTAL (agree to Sch. V, line 24, col. 8)		
		\$ 22,648

* Attach copy of IMRF notifications

**See instructions.

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. \$5916
- (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 N/A
- (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 NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 363,568
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. \$ 47,475 Has any meal income been offset against related costs? N/A 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? 89
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.