

		FOR BHF USE				

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2006
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2006)

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

I. IDPH Facility ID Number: 0047811

Facility Name: LAKEVIEW LIVING CENTER

Address: 7270 SOUTH SHORE DRIVE CHICAGO 60649
 Number City Zip Code

County: COOK

Telephone Number: 773-721-7700 **Fax #** 773-721-9712

HFS ID Number: 363234108001

Date of Initial License for Current Owners: 05/23/1983

Type of Ownership:

<input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT	<input type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL
<input checked="" type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State
<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County
IRS Exemption Code <u>501(c)(3)</u>	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other
	<input type="checkbox"/> "Sub-S" Corp.	
	<input type="checkbox"/> Limited Liability Co.	
	<input type="checkbox"/> Trust	
	<input type="checkbox"/> Other	

In the event there are further questions about this report, please contact:
Name: ROB KEIME **Telephone Number:** 309-685-0595 EXT. 304

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 07/01/2005 to 06/30/2006 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

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

Officer or Administrator of Provider	(Signed) _____	(Date) _____
	(Type or Print Name) <u>VINCENT EVERSON</u>	
	(Title) <u>PRESIDENT & CEO</u>	
Paid Preparer	(Signed) _____	(Date) _____
	(Print Name and Title) _____	
	(Firm Name & Address) _____	
	(Telephone) () _____ Fax # () _____	

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
 201 S. Grand Avenue East
 Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number LAKEVIEW LIVING CENTER# 0047811 Report Period Beginning: 07/01/2005 Ending: 06/30/2006

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 3 4 5 Patient Days by Level of Care and Primary Source of Payment			
		Medicaid Recipient	Private Pay	Other	
8	SNF				8
9	SNF/PED				9
10	ICF				10
11	ICF/DD	<u>42,054</u>	<u>365</u>		<u>42,419</u>
12	SC				12
13	DD 16 OR LESS				13
14	TOTALS	<u>42,054</u>	<u>365</u>		<u>42,419</u>

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 80.15%

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

704 (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)

NONEF. 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/AMedicare Intermediary N/A

IV. ACCOUNTING BASIS

ACCURAL MODIFIED CASH* CASH* Is your fiscal year identical to your tax year? YES NO Tax Year: 06/30/2006 Fiscal Year: 06/30/2006

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

Facility Name & ID Number LAKEVIEW LIVING CENTER # 0047811 Report Period Beginning: 07/01/2005 Ending: 06/30/2006

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	224,413	31,814	17,630	273,857		273,857		273,857			1
2	Food Purchase		153,424		153,424		153,424		153,424			2
3	Housekeeping	105,216	26,135		131,351		131,351		131,351			3
4	Laundry	49,454	17,612	806	67,872		67,872		67,872			4
5	Heat and Other Utilities			136,839	136,839		136,839		136,839			5
6	Maintenance	77,163		69,536	146,699		146,699	(17,679)	129,020			6
7	Other (specify):*											7
8	TOTAL General Services	456,246	228,985	224,811	910,042		910,042	(17,679)	892,363			8
	B. Health Care and Programs											
9	Medical Director											9
10	Nursing and Medical Records	2,366,429	16,697	85,664	2,468,790		2,468,790		2,468,790			10
10a	Therapy			21,212	21,212		21,212		21,212			10a
11	Activities		34,712		34,712		34,712		34,712			11
12	Social Services	21,627		40,400	62,027		62,027		62,027			12
13	CNA Training											13
14	Program Transportation			25,929	25,929		25,929		25,929			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	2,388,056	51,409	173,205	2,612,670		2,612,670		2,612,670			16
	C. General Administration											
17	Administrative	69,904		345,152	415,056		415,056		415,056			17
18	Directors Fees			19,526	19,526		19,526		19,526			18
19	Professional Services			56,083	56,083		56,083		56,083			19
20	Dues, Fees, Subscriptions & Promotions			11,688	11,688		11,688		11,688			20
21	Clerical & General Office Expenses	111,066	22,512	27,036	160,614		160,614		160,614			21
22	Employee Benefits & Payroll Taxes			615,880	615,880		615,880		615,880			22
23	Inservice Training & Education			46,803	46,803		46,803		46,803			23
24	Travel and Seminar			3,048	3,048		3,048		3,048			24
25	Other Admin. Staff Transportation			4,232	4,232		4,232		4,232			25
26	Insurance-Prop.Liab.Malpractice			43,906	43,906		43,906		43,906			26
27	Other (specify):*											27
28	TOTAL General Administration	180,970	22,512	1,173,354	1,376,836		1,376,836		1,376,836			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,025,272	302,906	1,571,370	4,899,548		4,899,548	(17,679)	4,881,869			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

#0047811

Report Period Beginning: 07/01/2005 Ending: 06/30/2006

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			141,605	141,605		141,605	15,353	156,958			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			367,598	367,598		367,598	(49,648)	317,950			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds			8,452	8,452		8,452		8,452			34
35	Rent-Equipment & Vehicles			11,178	11,178		11,178		11,178			35
36	Other (specify):*											36
37	TOTAL Ownership			528,833	528,833		528,833	(34,295)	494,538			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			352,668	352,668		352,668		352,668			42
43	Other (specify):*			1,398,709	1,398,709		1,398,709	(1,398,709)				43
44	TOTAL Special Cost Centers			1,751,377	1,751,377		1,751,377	(1,398,709)	352,668			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,025,272	302,906	3,851,580	7,179,758		7,179,758	(1,450,683)	5,729,075			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

0047811

Report Period Beginning: 07/01/2005

Ending: 06/30/2006

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	(1,400,147)	43		3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space	(978)	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	(46,676)	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	(2,972)	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	2,238	43		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	(800)	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 GAIN ON SALE	(1,348)	30		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (1,450,683)		\$	30

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

		1	2	
		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)			34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (1,450,683)		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

BHF USE ONLY						
48		49		50		51
						52

STATE OF ILLINOIS
LAKEVIEW LIVING CENTER

ID# 0047811
Report Period Beginning: 07/01/2005
Ending: 06/30/2006

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

0047811

Report Period Beginning:

07/01/2005

Ending:

06/30/2006

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	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	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	(978)	0	0	0	(16,701)	0	0	0	0	0	0	(17,679)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(978)	0	0	0	(16,701)	0	0	0	0	0	0	(17,679)	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	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	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	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	0	0	0	0	0	0	0	0	0	0	0	0	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(978)	0	0	0	(16,701)	0	0	0	0	0	0	(17,679)	29

STATE OF ILLINOIS

Facility Name & ID Number LAKEVIEW LIVING CENTER

0047811

Report Period Beginning:

07/01/2005 Ending:

Summary B

06/30/2006

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	0	0	0	0	16,701	0	0	0	0	0	0	16,701	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(49,648)	0	0	0	0	0	0	0	0	0	0	(49,648)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(49,648)	0	0	0	16,701	0	0	0	0	0	0	(32,947)	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):*	(1,398,709)	0	0	0	0	0	0	0	0	0	0	(1,398,709)	43
44	TOTAL Special Cost Centers	(1,398,709)	0	0	0	0	0	0	0	0	0	0	(1,398,709)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(1,449,335)	0	0	0	0	0	0	0	0	0	0	(1,449,335)	45

Facility Name & ID Number LAKEVIEW LIVING CENTER

0047811

Report Period Beginning: 07/01/2005 Ending: 06/30/2006

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: Adjustments for Related Organization Costs (7 minus 4)
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	
1	V	18 BOARD FEES	\$ 7,212	RESIDENTIAL CENTERS 07/01/05 TO 03/31/06	100.00%	\$ 7,212	\$
2	V	19 PROFESSIONAL FEES	29,927	RESIDENTIAL CENTERS 07/01/05 TO 03/31/06	100.00%	29,927	
3	V	20 LICENSE DUES	11	RESIDENTIAL CENTERS 07/01/05 TO 03/31/06	100.00%	11	
4	V	21 OFFICE SUPPLIES	7,034	RESIDENTIAL CENTERS 07/01/05 TO 03/31/06	100.00%	7,034	
5	V	22 INSERVICE TRAVEL	649	RESIDENTIAL CENTERS 07/01/05 TO 03/31/06	100.00%	649	
6	V	32 INTEREST EXPENSE	42,503	RESIDENTIAL CENTERS 07/01/05 TO 03/31/06	100.00%	42,503	
7	V			RESIDENTIAL CENTERS 07/01/05 TO 03/31/06	100.00%		
8	V	32 INTEREST INCOME	(14,078)	RESIDENTIAL CENTERS 07/01/05 TO 03/31/06	100.00%	(14,078)	
9	V			RESIDENTIAL CENTERS 07/01/05 TO 03/31/06			
10	V						
11	V						
12	V						
13	V						
14	Total		\$ 73,258			\$ 73,258	\$ *

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

Facility Name & ID Number LAKEVIEW LIVING CENTER

0047811

Report Period Beginning: 07/01/2005 Ending: 06/30/2006

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	18 BOARD FEES	\$ 3,809	PROGRESSIVE HOUSING, INC. 04/01/06 TO 05/31/06	100.00%	\$ 3,809	\$
16	V	19 PROFESSIONAL FEES	3,685	PROGRESSIVE HOUSING, INC. 04/01/06 TO 05/31/06	100.00%	3,685	
17	V	21 OFFICE SUPPLIES	1,955	PROGRESSIVE HOUSING, INC. 04/01/06 TO 05/31/06	100.00%	1,955	
18	V	22 INSERVICE TRAVEL	428	PROGRESSIVE HOUSING, INC. 04/01/06 TO 05/31/06	100.00%	428	
19	V						
20	V						
21	V						
22	V						
23	V						
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 9,877			\$ 9,877	\$ *

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	18 BOARD FEES	\$ 1701	PROGRESSIVE HOUSING, INC. 06/01/06 TO 06/30/06	100.00%	\$ 1701	\$	15
16	V	19 PROFESSIONAL FEES	6,809	PROGRESSIVE HOUSING, INC. 06/01/06 TO 06/30/06	100.00%	6,809		16
17	V	21 OFFICE SUPPLIES	781	PROGRESSIVE HOUSING, INC. 06/01/06 TO 06/30/06	100.00%	781		17
18	V	22 INSERVICE TRAVEL	189	PROGRESSIVE HOUSING, INC. 06/01/06 TO 06/30/06	100.00%	189		18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$ 9,480			\$ 9,480	\$ *	39

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

Facility Name & ID Number LAKEVIEW LIVING CENTER

0047811

Report Period Beginning: 07/01/2005 Ending: 06/30/2006

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	\$ 338,651	CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	\$ 338,651		15
16	V	18 DIRECTORS FEES	6,804	CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	6,804		16
17	V	19 PROFESSIONAL FEES	11,148	CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	11,148		17
18	V	20 DUES, FEES	3,862	CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	3,862		18
19	V	22 EMPLOYEE BENEFITS	66,062	CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	66,062		19
20	V	23 INSERVICE EDUCATION	15,993	CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	15,993		20
21	V	24 TRAVEL SEMINAR	351	CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	351		21
22	V	26 INSURANCE	8,144	CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	8,144		22
23	V	30 DEPRECIATION		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	16,701	16,701	23
24	V	32 INTEREST	2,531	CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	2,531		24
25	V	34 RENT	8,452	CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	8,452		25
26	V	35 EQUIPMENT RENTAL	544	CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	544		26
27	V	5 UTILITIES	4,275	CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	4,275		27
28	V	6 MAINTENANCE	18,736	CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	2,035	(16,701)	28
29	V	43 NONALLOWABLE	3,196	CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	3,196		29
30	V	32 INTEREST INCOME	(321)	CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	(321)		30
31	V	32 MISC INCOME	(16,543)	CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	(16,543)		31
32	V	3 HOUSEKEEPING	1,210	CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	1,210		32
33	V	21 OFFICE	11,300	CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	11,300		33
34	V	11 ACTIVITIES	104	CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	104		34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$ 484,499			\$ 484,499	\$ *	39

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

Facility Name & ID Number LAKEVIEW LIVING CENTER # 0047811 Report Period Beginning: 07/01/2005 Ending: 06/30/2006

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	7,463	3HRS/MTG	1.00	DIR. FEES	\$ 4,537	L18, C8	1
2	SHAWN JEFFERS	VICE CHAIRMAN	BOARD MEMBE	NONE	7,003	3HRS/MTG	1.00	DIR. FEES	4,197	L18, C8	2
3	EDWARD CHILDERS	SECRETARY	BOARD MEMBE	NONE	7,463	3HRS/MTG	1.00	DIR. FEES	4,537	L18, C8	3
4	ROBERT BAUER	TREASURER	BOARD MEMBE	NONE	2,311	3HRS/MTG	1.00	DIR. FEES	2,489	L18, C8	4
5	CORA FLOTA	DIRECTOR	BOARD MEMBE	NONE	4,114	3HRS/MTG	1.00	DIR. FEES	686	L18, C8	5
6	ORLAND BAUER	DIRECTOR	BOARD MEMBE	NONE	6,866	3HRS/MTG	1.00	DIR. FEES	2,734	L18, C8	6
7	KAY SCHUMAN JOHNSON	DIRECTOR	BOARD MEMBE	NONE	2,854	3HRS/MTG	1.00	DIR. FEES	346	L18, C8	7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 19,526		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

0047811 Report Period Beginning: 07/01/2005

Ending: 6/30/2006

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. 61617
 Phone Number (309-685-0595
 Fax Number (309-685-8463

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	18	BOARD FEES	NUMBER OF BEDS	193	4	\$ 9,600	\$ 145	\$ 7,212	1
2	19	PROFESSIONAL FEES	NUMBER OF BEDS	193	4	39,834	145	29,927	2
3	20	LICENSE DUES	NUMBER OF BEDS	193	4	15	145	11	3
4	21	OFFICE SUPPLIES	NUMBER OF BEDS	193	4	9,363	145	7,034	4
5	22	INSERVICE TRAVEL	NUMBER OF BEDS	193	4	863	145	649	5
6	32	INTEREST EXPENSE	NUMBER OF BEDS	193	4	56,572	145	42,503	6
7	32	INTEREST INCOME	NUMBER OF BEDS	193	4	(18,738)	145	(14,078)	7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 97,509	\$	\$ 73,258	25

Facility Name & ID Number LAKEVIEW LIVING CENTER

0047811 Report Period Beginning: 07/01/2005

Ending: 6/30/2006

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization PROGRESSIVE HOUSING, INC.
 Street Address 2020 W. WAR MEMORIAL DR. SUITE 103
 City / State / Zip Code PEORIA, IL. 61617
 Phone Number (309-685-0595
 Fax Number (309-685-8463

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	18	BOARD FEES	NUMBER OF BEDS	335	17	\$ 8,800	\$ 145	\$ 3,809	1
2	19	PROFESSIONAL FEES	NUMBER OF BEDS	335	17	8,515	145	3,685	2
3	21	OFFICE SUPPLIES	NUMBER OF BEDS	335	17	4,516	145	1,955	3
4	22	INSERVICE TRAVEL	NUMBER OF BEDS	335	17	989	145	428	4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 22,820	\$	\$ 9,877	25

Facility Name & ID Number LAKEVIEW LIVING CENTER

0047811 Report Period Beginning: 07/01/2005

Ending: 6/30/2006

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization PROGRESSIVE HOUSING, INC.
 Street Address 2020 W. WAR MEMORIAL DR. SUITE 103
 City / State / Zip Code PEORIA, IL. 61617
 Phone Number (309-685-0595
 Fax Number (309-685-8463

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	18	BOARD FEES	NUMBER OF BEDS	341	18	\$ 4,000	\$ 145	\$ 1,701	1
2	19	PROFESSIONAL FEES	NUMBER OF BEDS	341	18	16,013	145	6,809	2
3	21	OFFICE SUPPLIES	NUMBER OF BEDS	341	18	1,838	145	781	3
4	22	INSERVICE TRAVEL	NUMBER OF BEDS	341	18	445	145	189	4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 22,296	\$	\$ 9,480	25

Facility Name & ID Number LAKEVIEW LIVING CENTER

0047811 Report Period Beginning: 07/01/2005

Ending: 6/30/2006

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. 61617
 Phone Number (309-685-0595
 Fax Number (309-685-8463

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	17	ADMINISTRATIVE COST	341	18	\$ 796,413	\$ 715,898	145	\$ 338,651	1
2	18	DIRECTORS FEES	341	18	16,000		145	6,804	2
3	19	PROFESSIONAL FEES	341	18	26,217		145	11,148	3
4	20	DUES, FEES	341	18	9,084		145	3,862	4
5	22	EMPLOYEE BENEFITS	341	18	155,362		145	66,062	5
6	23	INSERVICE EDUCATION	341	18	37,610		145	15,993	6
7	24	TRAVEL SEMINAR	341	18	825		145	351	7
8	26	INSURANCE	341	18	19,152		145	8,144	8
9	30	DEPRECIATION	341	18	39,276		145	16,701	9
10	32	INTEREST	341	18	5,951		145	2,531	10
11	34	RENT	341	18	19,876		145	8,452	11
12	35	EQUIPMENT RENTAL	341	18	1,280		145	544	12
13	5	UTILITIES	341	18	10,053		145	4,275	13
14	6	MAINTENANCE	341	18	4,785		145	2,035	14
15	43	NONALLOWABLE	341	18	7,517		145	3,196	15
16	32	INTEREST INCOME	341	18	(755)		145	(321)	16
17	32	MISC INCOME	341	18	(38,904)		145	(16,543)	17
18	3	HOUSEKEEPING	341	18	2,847		145	1,210	18
19	21	OFFICE	341	18	26,574		145	11,300	19
20	11	ACTIVITIES	341	18	243		145	104	20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 1,139,406	\$ 715,898		\$ 484,499	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	Name of Lender	2		3	4	5	6		7	8	9	10						
		Related**					Purpose of Loan	Monthly Payment Required					Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO											Original	Balance			
A. Directly Facility Related																		
Long-Term																		
1	IL HEALTH FAC AUTH. BONDS	X		ACQUISITION OF FACILITY	ANNUAL PMT	12/01/92	\$ 6,160,000	\$	03/08/06	8.5000	\$ 254,050	1						
2	IL HEALTH FAC AUTH. BONDS	X		ACQUISITION OF FACILITY	ANNUAL PMT	03/09/06	2,351,739	2,351,739	08/15/26	6.7500	49,946	2						
3												3						
4	BANTERRA BANK		X	PURCHASE OF VEHICLES	\$328.14	07/15/04	16,631	10,887	07/15/09	6.7500	849	4						
5												5						
Working Capital																		
6	HEALTHCARE BUSINESS CREDIT	X		WORKING CAPITAL		5/12/2003	700,000		03/08/06	10.5000	57,250	6						
7				OFFSET INTERST INCOME/ NONALLOWABLE INT.							(46,676)	7						
8											2,531	8						
9	TOTAL Facility Related				\$328.14		\$ 9,228,370	\$ 2,362,626			\$ 317,950	9						
B. Non-Facility Related*																		
10												10						
11												11						
12												12						
13												13						
14	TOTAL Non-Facility Related						\$	\$			\$	14						
15	TOTALS (line 9+line14)						\$ 9,228,370	\$ 2,362,626			\$ 317,950	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.)

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

B. Real Estate Taxes

<p>Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.</p>																							
1. Real Estate Tax accrual used on 2005 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 2006 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																				
<p>Real Estate Tax History:</p> <table border="1"> <tr> <td>Real Estate Tax Bill for Calendar Year:</td> <td>2001</td> <td>_____</td> <td>8</td> </tr> <tr> <td></td> <td>2002</td> <td>_____</td> <td>9</td> </tr> <tr> <td></td> <td>2003</td> <td>_____</td> <td>10</td> </tr> <tr> <td></td> <td>2004</td> <td>_____</td> <td>11</td> </tr> <tr> <td></td> <td>2005</td> <td>_____</td> <td>12</td> </tr> </table>				Real Estate Tax Bill for Calendar Year:	2001	_____	8		2002	_____	9		2003	_____	10		2004	_____	11		2005	_____	12
Real Estate Tax Bill for Calendar Year:	2001	_____	8																				
	2002	_____	9																				
	2003	_____	10																				
	2004	_____	11																				
	2005	_____	12																				
		FOR BHF USE ONLY																					
	13	FROM R. E. TAX STATEMENT FOR 2005 \$	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.

Facility Name & ID Number LAKEVIEW LIVING CENTER

0047811 Report Period Beginning:

07/01/2005 Ending:

06/30/2006

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	<u>RESIDENT CARE</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

0047811

Report Period Beginning:

07/01/2005

Ending:

06/30/2006

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	145		1988	1910	\$ 1,585,984	\$ 45,314	35	\$ 45,314	\$	\$ 796,666	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		8,095	16
17		BUILDING IMPROVEMENT		1993	112,022	7,468	15	7,468		99,264	17
18		BUILDING IMPROVEMENT		1993	115,471	7,698	15	7,698		96,226	18
19		BUILDING IMPROVEMENT		1994			10				19
20		BUILDING IMPROVEMENT		1995	32,918	2,195	15	2,195		24,815	20
21		INSTALL FIRE HOUSE		1995	1,228	82	15	82		867	21
22		ELEVATOR IMPROVEMENTS		1996	3,356	224	15	224		2,313	22
23		RECEPTION AREA		1996	1,598	107	15	107		1,092	23
24		TWO SETS OF STEEL DOORS		1995	3,250	217	15	217		2,311	24
25		CABINETS IN RECEPTION AREA		1995	3,500	233	15	233		2,469	25
26		MOTOR FOR ELEVATOR		1996	2,042	136	15	136		1,350	26
27		TUB RESURFACING		1996	4,900	327	15	327		3,212	27
28		CONCRETE RAMP		1996	700	46	15	46		455	28
29		ROOF SHAFT & EXHAUST		1996	1,110	74	15	74		722	29
30		FLOOR DRAIN		1997	2,300	153	15	153		1,431	30
31		BOX ELEVATOR		1997	1,950	130	15	130		1,192	31
32		CONCRETE LUNCH AREA		1997	4,313	286	15	286		2,635	32
33		ROOF WORK		1997	45,658	3,044	15	3,044		27,902	33
34		BOX ON ELEVATOR		1998	525	35	15	35		312	34
35		LIGHTING		1998	2,715	181	15	181		1,584	35
36		PLUMBING		1998	700	47	15	47		397	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

0047811

Report Period Beginning:

07/01/2005 Ending: 06/30/2006

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	\$	\$ 1,485	37
38	ROOF TOP EXHAUST FAN	1998	635	42	15	42		363	38
39	ELECTRIC DOOR STRIKE	1998	582	39	15	39		346	39
40	GLASS	1998	679	45	15	45		400	40
41	CARPET	1999	518	35	15	35		256	41
42	DOOR	1999	680	45	15	45		302	42
43	BATHROOM RENOVATIONS	2000	8,800	587	15	587		3,263	43
44	PLUMBING	2001	2,100	140	15	140		723	44
45	SHOWER BASE AND TILES	2001	2,200	147	15	147		733	45
46	TUCK POINTING BRICK	2001	43,284	2,886	15	2,886		13,707	46
47	STEEL DOORS	2002	1,430	95	15	95		421	47
48	RESURFACE BATHTUB	2002	1,120	75	15	75		324	48
49	WATER LINE MOTOR	2002	1,275	85	15	85		361	49
50	ELEVATOR EDGE	2001	1,696	113	15	113		556	50
51	ELEVATOR DOORS	2002	920	61	15	61		271	51
52	WATER LINE	2002	1,750	117	15	117		477	52
53	HOPKINS ELEVATOR REPAIR	2004	1,009	67	15	67		179	53
54	DURAGLAZE TUB REFURNISHING	2004	2,845	190	15	190		411	54
55	ROOF REPAIRS	2004	1,050	70	15	70		140	55
56	FLOORING	2004	2,928	195	15	195		390	56
57	WINDOWS	2004	1,885	126	15	126		220	57
58	ELEVATOR REPAIRS	2004	1,480	99	15	99		173	58
59	ELEVATOR DRIVE UNIT	2005	4,273	237	15	237		237	59
60	EXTERNAL CABLE SETUP	2005	1,264	70	15	70		70	60
61	NEW WINDOWS	2005	560	31	15	31		31	61
62	TUB RESURFACING	2005	3,505	137	15	137		137	62
63	NEW ELEVATOR GENERATOR	2006	5,324	29	15	29		29	63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 2,330,491	\$ 74,538		\$ 74,538	\$	\$ 1,400,108	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	\$ 490,969	\$ 49,537	\$ 49,537	\$	5-10 YRS	\$ 261,835	71
72	Current Year Purchases	44,761	3,286	3,286		5-10 YRS	3,286	72
73	Fully Depreciated Assets	593,500					593,500	73
74								74
75	TOTALS	\$ 1,129,230	\$ 52,823	\$ 52,823	\$		\$ 858,621	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	2002 FORD VAN	2002	\$ 23,986	\$ 4,797	\$ 4,797	\$	5	\$ 19,589	76
77	RESIDENT TRANSPORTATION	2003 FORD VAN	2003	24,501	4,901	4,901		5	15,109	77
78	RESIDENT TRANSPORTATION	2004 CHEVY VENTURE	2004	18,511	3,702	3,702		5	8,248	78
79	RESIDENT TRANSPORTATION	2001 CHEVY LUMINA SOLD	2004		844	844		5		79
80	TOTALS			\$ 66,998	\$ 14,244	\$ 14,244	\$		\$ 42,946	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)		\$ 3,568,235	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)		\$ 141,605	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)		\$ 141,605	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)		\$ 2,301,675	85

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

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

G. Construction-in-Progress

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

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

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

Facility Name & ID Number LAKEVIEW LIVING CENTER

0047811

Report Period Beginning: 07/01/2005

Ending: 06/30/2006

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.	_____ /2007	\$ _____
13.	_____ /2008	\$ _____
14.	_____ /2009	\$ _____

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: \$ 11,178

Description: COPIER \$8434, DISHWASHER \$2199, CORP. ALLOC \$545

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

	Service	1 Schedule V Line & Column Reference	2 Staff		4 Outside Practitioner (other than consultant)		6 Supplies (Actual or Allocated)	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	5 Units 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):									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.

Facility Name & ID Number LAKEVIEW LIVING CENTER

0047811

Report Period Beginning: 07/01/2005

Ending:

06/30/2006

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 06/30/2006

(last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 1,500	\$	1
2	Cash-Patient Deposits	56,211		2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance 101,633)	1,086,231		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	741		6
7	Other Prepaid Expenses	4,998		7
8	Accounts Receivable (owners or related parties)	4,555,193		8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 5,704,874	\$	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	744,507		15
16	Equipment, at Historical Cost	1,196,228		16
17	Accumulated Depreciation (book methods)	(2,301,675)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	419,165		21
22	Other Long-Term Assets (specify):			22
23	Other(specify): LOAN COST	57,519		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,743,244	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 7,448,118	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 510,245	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	56,211		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	139,951		30
31	Accrued Taxes Payable (excluding real estate taxes)	11,760		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	48,887		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)	\$ 767,054	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	10,888		39
40	Mortgage Payable			40
41	Bonds Payable	2,351,739		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)	\$ 2,362,627	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 3,129,681	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 4,318,437	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 7,448,118	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 4,468,735	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 4,468,735	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(150,298)	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)	\$ (150,298)	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)	\$ 4,318,437	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number LAKEVIEW LIVING CENTER

0047811

Report Period Beginning: 07/01/2005

Ending: 06/30/2006

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	\$ 5,535,322	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 5,535,322	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	1,400,147	9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space	978	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)	\$ 1,401,125	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	46,676	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 46,676	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	PRIOR GAIN ON LEGAL SETTLEMENT	44,989	28
28a	GAIN ON SALE OF VEHICLE	1,348	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 46,337	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 7,029,460	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	910,042	31
32	Health Care	2,612,670	32
33	General Administration	1,376,836	33
B. Capital Expense			
34	Ownership	528,833	34
C. Ancillary Expense			
35	Special Cost Centers	1,398,709	35
36	Provider Participation Fee	352,668	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 7,179,758	40
41	Income before Income Taxes (line 30 minus line 40)**	(150,298)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (150,298)	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

0047811

Report Period Beginning: 07/01/2005

Ending:

06/30/2006

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	1,968	2,118	\$ 54,001	\$ 25.50	1
2	Assistant Director of Nursing	2,186	2,449	46,308	18.91	2
3	Registered Nurses					3
4	Licensed Practical Nurses	14,767	16,015	311,358	19.44	4
5	CNAs & Orderlies					5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants					10
11	Social Service Workers	1,956	2,208	21,627	9.79	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	21,278	22,916	224,413	9.79	15
16	Dishwashers					16
17	Maintenance Workers	5,934	6,340	77,163	12.17	17
18	Housekeepers	10,208	11,089	105,216	9.49	18
19	Laundry	3,906	4,514	49,454	10.96	19
20	Administrator	1,984	2,113	69,904	33.08	20
21	Assistant Administrator					21
22	Other Administrative	9,067	9,840	111,066	11.29	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)	14,646	15,845	238,964	15.08	28
29	Resident Services Coordinator	1,845	2,055	39,054	19.00	29
30	Habilitation Aides (DD Homes)	147,403	163,970	1,654,280	10.09	30
31	Medical Records	2,910	2,926	22,464	7.68	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	240,058	264,398	\$ 3,025,272 *	\$ 11.44	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	119	\$ 15,512	L1, C3	35
36	Medical Director				36
37	Medical Records Consultant				37
38	Nurse Consultant	98	2,438	L10, C3	38
39	Pharmacist Consultant	MONTHLY	1,584	L10, C3	39
40	Physical Therapy Consultant	88	4,900	L10A, C3	40
41	Occupational Therapy Consultant	41	2,282	L10A, C3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	300	14,030	L10A, C3	43
44	Activity Consultant	7	528	L12, C3	44
45	Social Service Consultant	721	40,400	L12, C3	45
46	Other(specify) PSYCHOLOGICAL	MONTHLY	48,000	L10, C3	46
47					47
48					48
49	TOTAL (lines 35 - 48)	1,374	\$ 129,674		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$		50
51	Licensed Practical Nurses	430	17,070	L10 C3	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	430	\$ 17,070		53

Facility Name & ID Number LAKEVIEW LIVING CENTER

0047811

Report Period Beginning: 07/01/2005

Ending: 06/30/2006

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
JOHN MIRECKI	ADMINISTRATOR	0	\$ 69,904	Workers' Compensation Insurance	\$ 42,941	IDPH License Fee	\$ 995	
				Unemployment Compensation Insurance	73,199	Advertising: Employee Recruitment		
				FICA Taxes	250,933	Health Care Worker Background Check		
				Employee Health Insurance	163,371	(Indicate # of checks performed)		
				Employee Meals	46,106	Patient Background Checks	230 2,301	
				Illinois Municipal Retirement Fund (IMRF)*		HELP WANTED ADS	1,320	
				UNION PENSION FUND	31,430	VEHICLE LICENSE	254	
				EMPLOYEE MORAL	7,900	PARENT ALLOC	3,863	
						CITY LICENSE/PERMITS	2,344	
						MES/MAG. SUBSCRIPTIONS	611	
						Less: Public Relations Expense	()	
						Non-allowable advertising	()	
						Yellow page advertising	()	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)						TOTAL (agree to Sch. V, line 20, col. 8)		
					\$ 615,880	\$ 11,688		
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Description			Amount	Description	Line #	Amount	Description	Amount
MANAGEMENT FEES ADJ ON SCHEDULE 6C			\$ 338,651	N/A			Out-of-State Travel	\$
PERSONNEL PLANNERS, INC UC CONSULTATION			3,646					
TERRY WISECARVER QUALITY CONTROL			735				In-State Travel	
ILL ASSOC OF HEATHCARE UNION NEGOTIATION			2,120				CPI CERTIFICATION	169
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 345,152				LONG TERM CARE NURSE	271
							INSTITUTE FOR PUBLIC POLICY	92
C. Professional Services							Seminar Expense	
Vendor/Payee	Type		Amount				CPI CERTIFICATION	1,199
LAWRENCE MANSON	LEGAL		17,195				QMRP LEADERSHIP CONFERENCE	330
HBCC	ACCOUNTING		2,476				INSTITUTE FOR PUBLIC POLICY	987
HEINOLD-BANWART	ACCOUNTING		19,032				Entertainment Expense	()
WESTERVELT JOHNSON	LEGAL		97				(agree to Sch. V, line 24, col. 8)	
LAWRENCE MANSON	LEGAL		5,672					
HEINOLD-BANWART	ACCOUNTING		5,198				TOTAL	\$ 3,048
JP MORGAN CHASE	TRUSTEE FEES		2,410					
JONES DAY	LEGAL		1,718					
CENTER FOR DISAB. & ELDER L	LEGAL		800					
WELLS FARGO BANK	TRUSTEE FEES		1,304					
ROUND TABLE DESIGN	SURVEY		181					
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 56,083	TOTAL		\$		

* 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? NO
If YES, give association name and amount. N/A
- (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? _____
- (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 X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 352,668
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. \$ 46,106 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? 91.7
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?
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? _____
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.