

		FOR BHF USE					

LL1

2007
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2007)

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 License 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: 371238076009

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©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 07/01/2006 to 06/30/2007 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: 07/01/2006 Ending: 06/30/2007

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	145	Intermediate/DD	145	52,925	4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	145	TOTALS	145	52,925	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	32,801	365		33,166
12	SC				12
13	DD 16 OR LESS				13
14	TOTALS	32,801	365		33,166

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 62.67%

D. How many bed-hold days during this year were paid by the Department? 690 (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

ACCURAL MODIFIED CASH* CASH*

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

Tax Year: 06/30/2007 Fiscal Year: 06/30/2007

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

Facility Name & ID Number LAKEVIEW LIVING CENTER # 0047811 Report Period Beginning: 07/01/2006 Ending: 06/30/2007

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	205,945	22,310	11,143	239,398		239,398		239,398		1
2	Food Purchase		119,750		119,750		119,750		119,750		2
3	Housekeeping	100,828	20,264		121,092		121,092	1,497	122,589		3
4	Laundry	52,988	13,785	1,143	67,916		67,916		67,916		4
5	Heat and Other Utilities			117,118	117,118		117,118	4,866	121,984		5
6	Maintenance	58,515		40,715	99,230		99,230	1,654	100,884		6
7	Other (specify):*										7
8	TOTAL General Services	418,276	176,109	170,119	764,504		764,504	8,017	772,521		8
	B. Health Care and Programs										
9	Medical Director										9
10	Nursing and Medical Records	1,784,713	18,633	169,693	1,973,039		1,973,039	155	1,973,194		10
10a	Therapy			20,850	20,850		20,850		20,850		10a
11	Activities		26,157		26,157		26,157		26,157		11
12	Social Services	17,497		34,440	51,937		51,937		51,937		12
13	CNA Training										13
14	Program Transportation			25,293	25,293		25,293		25,293		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,802,210	44,790	250,276	2,097,276		2,097,276	155	2,097,431		16
	C. General Administration										
17	Administrative	81,411			81,411		81,411	224,229	305,640		17
18	Directors Fees			17,103	17,103		17,103		17,103		18
19	Professional Services			32,534	32,534		32,534	395	32,929		19
20	Dues, Fees, Subscriptions & Promotions			4,728	4,728		4,728	3,065	7,793		20
21	Clerical & General Office Expenses	105,712	6,196	33,471	145,379		145,379	33,120	178,499		21
22	Employee Benefits & Payroll Taxes			348,843	348,843		348,843	48,483	397,326		22
23	Inservice Training & Education			15,395	15,395		15,395	13,446	28,841		23
24	Travel and Seminar			1,913	1,913		1,913	1,597	3,510		24
25	Other Admin. Staff Transportation			6,081	6,081		6,081		6,081		25
26	Insurance-Prop.Liab.Malpractice			24,665	24,665		24,665	8,454	33,119		26
27	Other (specify):*										27
28	TOTAL General Administration	187,123	6,196	484,733	678,052		678,052	332,789	1,010,841		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,407,609	227,095	905,128	3,539,832		3,539,832	340,961	3,880,793		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: 07/01/2006 Ending: 06/30/2007

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			140,865	140,865		140,865	14,192	155,057			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			171,092	171,092		171,092	(44,500)	126,592			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds							9,026	9,026			34
35	Rent-Equipment & Vehicles			4,038	4,038		4,038	604	4,642			35
36	Other (specify):*											36
37	TOTAL Ownership			315,995	315,995		315,995	(20,678)	295,317			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			332,120	332,120		332,120		332,120			42
43	Other (specify):*			1,146,071	1,146,071		1,146,071	(1,146,071)				43
44	TOTAL Special Cost Centers			1,478,191	1,478,191		1,478,191	(1,146,071)	332,120			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,407,609	227,095	2,699,314	5,334,018		5,334,018	(825,788)	4,508,230			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:

07/01/2006

Ending:

06/30/2007

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	BHF USE ONLY	
1	Day Care	\$ (1,108,121)	43	\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space	(1,266)	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	(43,496)	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	(2,949)	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	(42,649)	43		18
19	Entertainment				19
20	Contributions	(200)	43		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				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)	\$ (1,198,681)		\$	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))	\$ (1,198,681)		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: 07/01/2006
Ending: 06/30/2007

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:

07/01/2006

Ending:

06/30/2007

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	1,497	0	0	0	0	0	0	0	0	1,497	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	4,866	0	0	0	0	0	0	0	0	4,866	5
6	Maintenance	(1,266)	0	2,920	0	0	0	0	0	0	0	0	1,654	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(1,266)	0	9,283	0	8,017	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	155	0	0	0	0	0	0	0	0	155	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	155	0	155	16							
	C. General Administration													
17	Administrative	0	0	224,229	0	0	0	0	0	0	0	0	224,229	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	395	0	0	0	0	0	0	0	0	395	19
20	Fees, Subscriptions & Promotions	0	0	3,065	0	0	0	0	0	0	0	0	3,065	20
21	Clerical & General Office Expenses	0	0	33,120	0	0	0	0	0	0	0	0	33,120	21
22	Employee Benefits & Payroll Taxes	0	0	48,483	0	0	0	0	0	0	0	0	48,483	22
23	Inservice Training & Education	0	0	13,446	0	0	0	0	0	0	0	0	13,446	23
24	Travel and Seminar	0	0	1,597	0	0	0	0	0	0	0	0	1,597	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	8,454	0	0	0	0	0	0	0	0	8,454	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	0	0	332,789	0	332,789	28							
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(1,266)	0	342,227	0	340,961	29							

STATE OF ILLINOIS

Facility Name & ID Number LAKEVIEW LIVING CENTER

0047811

Report Period Beginning:

07/01/2006 Ending:

Summary B

06/30/2007

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	14,192	0	0	0	0	0	0	0	0	14,192	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(46,445)	0	1,945	0	0	0	0	0	0	0	0	(44,500)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	9,026	0	0	0	0	0	0	0	0	9,026	34
35	Rent-Equipment & Vehicles	0	0	604	0	0	0	0	0	0	0	0	604	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(46,445)	0	25,767	0	(20,678)	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):*	(1,150,970)	0	4,899	0	0	0	0	0	0	0	0	(1,146,071)	43
44	TOTAL Special Cost Centers	(1,150,970)	0	4,899	0	(1,146,071)	44							
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(1,198,681)	0	372,893	0	(825,788)	45							

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
<u>PROGRESSIVE HOUSING, INC.</u>	<u>100</u>	<u>SEE ATTACHED RELATED PARTY SCHEDULE</u>		<u>SEE ATTACHED RELATED PARTY SCHEDULE</u>		
<u>SEE ATTACHED SCHEDULE 7A</u>						

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	<u>18 BOARD FEES</u>	\$ <u>17,103</u>	<u>PROGRESSIVE HOUSING, INC.</u>	<u>100.00%</u>	\$ <u>17,103</u>	\$
2	V	<u>19 PROFESSIONAL FEES</u>	<u>31,532</u>	<u>PROGRESSIVE HOUSING, INC.</u>	<u>100.00%</u>	<u>31,532</u>	
3	V	<u>20 LICENSE, DUES</u>	<u>2</u>	<u>PROGRESSIVE HOUSING, INC.</u>	<u>100.00%</u>	<u>2</u>	
4	V	<u>21 GENERAL OFFICE</u>	<u>12,262</u>	<u>PROGRESSIVE HOUSING, INC.</u>	<u>100.00%</u>	<u>12,262</u>	
5	V	<u>23 INSERVICE TRAVEL</u>	<u>1,847</u>	<u>PROGRESSIVE HOUSING, INC.</u>	<u>100.00%</u>	<u>1,847</u>	
6	V	<u>32 INTEREST</u>	<u>33</u>	<u>PROGRESSIVE HOUSING, INC.</u>	<u>100.00%</u>	<u>33</u>	
7	V	<u>32 INTEREST INCOME</u>	<u>(16,252)</u>	<u>PROGRESSIVE HOUSING, INC.</u>	<u>100.00%</u>	<u>(16,252)</u>	
8	V						
9	V						
10	V						
11	V						
12	V						
13	V						
14	Total		\$ <u>46,527</u>			\$ <u>46,527</u>	\$ *

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

Facility Name & ID Number LAKEVIEW LIVING CENTER

0047811

Report Period Beginning: 07/01/2006 Ending: 06/30/2007

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	\$	CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	\$ 224,229	\$	224,229	15
16	V	19 PROFESSIONAL FEES		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	395		395	16
17	V	20 DUES, FEES		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	3,065		3,065	17
18	V	22 EMPLOYEE BENEFITS		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	48,483		48,483	18
19	V	23 INSERVICE EDUCATION		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	13,446		13,446	19
20	V	24 TRAVEL SEMINAR		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	1,597		1,597	20
21	V	26 INSURANCE		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	8,454		8,454	21
22	V	30 DEPRECIATION		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	14,192		14,192	22
23	V	32 INTEREST		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	1,868		1,868	23
24	V	34 RENT		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	9,026		9,026	24
25	V	35 EQUIPMENT RENTAL		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	604		604	25
26	V	5 UTILITIES		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	4,866		4,866	26
27	V	6 MAINTENANCE		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	2,920		2,920	27
28	V	43 NONALLOWABLE		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	4,899		4,899	28
29	V	32 MISC INCOME		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	77		77	29
30	V	3 HOUSEKEEPING		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	1,497		1,497	30
31	V	21 OFFICE		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	33,120		33,120	31
32	V	10 NURSING SUPPLIES		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	155		155	32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total		\$			\$ 372,893	\$ *	372,893	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: 07/01/2006 Ending: 06/30/2007

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	20 LICENSE DUES	\$ 11	RESIDENTIAL CENTERS 07/01/05 TO 02/28/07	100.00%	\$ 11	\$	15
16	V	19 PROFESSIONAL FEES	1,002	RESIDENTIAL CENTERS 07/01/05 TO 02/28/07	100.00%	1,002		16
17	V	21 OFFICE SUPPLIES	240	RESIDENTIAL CENTERS 07/01/05 TO 02/28/07	100.00%	240		17
18	V	32 INTEREST INCOME	(9,768)	RESIDENTIAL CENTERS 07/01/05 TO 02/28/07	100.00%	(9,768)		18
19	V	43 NONALLOWABLE	75	RESIDENTIAL CENTERS 07/01/05 TO 02/28/07	100.00%	75		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		\$ (8,440)			\$ (8,440)	\$ *	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: 07/01/2006 Ending: 06/30/2007

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	7,164	3HRS/MTG	1.00	DIR. FEES	\$ 3,636	L18, C8	1
2	SHAWN JEFFERS	VICE CHAIRMAN	BOARD MEMBE	NONE	7,164	3HRS/MTG	1.00	DIR. FEES	3,636	L18, C8	2
3	EDWARD CHILDERS	SECRETARY	BOARD MEMBE	NONE	7,164	3HRS/MTG	1.00	DIR. FEES	3,636	L18, C8	3
4	ROBERT BAUER	DIRECTOR	BOARD MEMBE	NONE	3,184	3HRS/MTG	1.00	DIR. FEES	1,616	L18, C8	4
5	CORA FLOTA	DIRECTOR	BOARD MEMBE	NONE	3,184	3HRS/MTG	1.00	DIR. FEES	1,616	L18, C8	5
6	ORLAND BAUER	TREASURER	BOARD MEMBE	NONE	5,837	3HRS/MTG	1.00	DIR. FEES	2,963	L18, C8	6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 17,103		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: 07/01/2006

Ending: 6/30/2007

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 PROGRESSIVE HOUSING, INC.
 Street Address 2020 W. WARMEMORIAL DR. SUITE 103
 City / State / Zip Code PEORIA, IL. 61614
 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	297	18	\$ 50,800	\$	100	\$ 17,103	1
2	19	PROFESSIONAL FEES	297	18	93,649		100	31,532	2
3	20	LICENSE, DUES	297	18	5		100	2	3
4	21	GENERAL OFFICE	297	18	36,417		100	12,262	4
5	23	INSERVICE TRAVEL	297	18	5,485		100	1,847	5
6	32	INTEREST	297	18	100		100	33	6
7	32	INTEREST INCOME	297	18	(48,268)		100	(16,252)	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				\$ 138,188	\$		\$ 46,527	25

Facility Name & ID Number LAKEVIEW LIVING CENTER

0047811 Report Period Beginning: 07/01/2006

Ending: 6/30/2007

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	297	18	\$ 665,960	\$ 665,960	100	\$ 224,229	1
2	19	PROFESSIONAL FEES	297	18	1,173		100	395	2
3	20	DUES, FEES	297	18	9,102		100	3,065	3
4	22	EMPLOYEE BENEFITS	297	18	143,996		100	48,483	4
5	23	INSERVICE EDUCATION	297	18	39,936		100	13,446	5
6	24	TRAVEL SEMINAR	297	18	4,744		100	1,597	6
7	26	INSURANCE	297	18	25,108		100	8,454	7
8	30	DEPRECIATION	297	18	42,150		100	14,192	8
9	32	INTEREST	297	18	5,547		100	1,868	9
10	34	RENT	297	18	26,806		100	9,026	10
11	35	EQUIPMENT RENTAL	297	18	1,795		100	604	11
12	5	UTILITIES	297	18	14,451		100	4,866	12
13	6	MAINTENANCE	297	18	8,673		100	2,920	13
14	43	NONALLOWABLE	297	18	14,551		100	4,899	14
15	32	MISC INCOME	297	18	228		100	77	15
16	3	HOUSEKEEPING	297	18	4,446		100	1,497	16
17	21	OFFICE	297	18	98,367		100	33,120	17
18	10	NURSING SUPPLIES	297	18	460		100	155	18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 1,107,493	\$ 665,960		\$ 372,893	25

Facility Name & ID Number LAKEVIEW LIVING CENTER

0047811 Report Period Beginning: 07/01/2006

Ending: 6/30/2007

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 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

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	20	LICENSE DUES	NUMBER OF BEDS	193	4	\$ 15	\$ 145	\$ 11	1
2	19	PROFESSIONAL FEES	NUMBER OF BEDS	193	4	1,334	145	1,002	2
3	21	OFFICE SUPPLIES	NUMBER OF BEDS	193	4	320	145	240	3
4	32	INTEREST INCOME	NUMBER OF BEDS	193	4	(13,002)	145	(9,768)	4
5	43	NONALLOWABLE	NUMBER OF BEDS	193	4	100	145	75	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					\$	\$	(8,440)	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 FACILITY	ANNUAL PMT	03/09/06	\$ 2,351,739	\$ 2,351,739	08/15/26	6.7500	\$ 167,611	1									
2	BANTERRA BANK	X	PURCHASE OF VEHICLES	\$328.14	07/15/04	16,631	7,584	07/15/09	6.7500	634	2									
3											3									
4											4									
5											5									
Working Capital																				
6			OFFSET INTERST INCOME/ NONALLOWABLE INT.							(43,496)	6									
7			MISC./PARENT ALLOCATION							1,843	7									
8											8									
9	TOTAL Facility Related			\$328.14		\$ 2,368,370	\$ 2,359,323			\$ 126,592	9									
B. Non-Facility Related*																				
10											10									
11											11									
12											12									
13											13									
14	TOTAL Non-Facility Related					\$	\$			\$	14									
15	TOTALS (line 9+line14)					\$ 2,368,370	\$ 2,359,323			\$ 126,592	15									

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

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

** 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 2006 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 2007 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>2002</td> <td>_____</td> <td>8</td> </tr> <tr> <td></td> <td>2003</td> <td>_____</td> <td>9</td> </tr> <tr> <td></td> <td>2004</td> <td>_____</td> <td>10</td> </tr> <tr> <td></td> <td>2005</td> <td>_____</td> <td>11</td> </tr> <tr> <td></td> <td>2006</td> <td>_____</td> <td>12</td> </tr> </table>				Real Estate Tax Bill for Calendar Year:	2002	_____	8		2003	_____	9		2004	_____	10		2005	_____	11		2006	_____	12
Real Estate Tax Bill for Calendar Year:	2002	_____	8																				
	2003	_____	9																				
	2004	_____	10																				
	2005	_____	11																				
	2006	_____	12																				
<table border="1"> <tr> <td colspan="4">FOR BHF USE ONLY</td> </tr> <tr> <td>13</td> <td>FROM R. E. TAX STATEMENT FOR 2006</td> <td>\$</td> <td>13</td> </tr> <tr> <td>14</td> <td>PLUS APPEAL COST FROM LINE 5</td> <td>\$</td> <td>14</td> </tr> <tr> <td>15</td> <td>LESS REFUND FROM LINE 6</td> <td>\$</td> <td>15</td> </tr> <tr> <td>16</td> <td>AMOUNT TO USE FOR RATE CALCULATION</td> <td>\$</td> <td>16</td> </tr> </table>				FOR BHF USE ONLY				13	FROM R. E. TAX STATEMENT FOR 2006	\$	13	14	PLUS APPEAL COST FROM LINE 5	\$	14	15	LESS REFUND FROM LINE 6	\$	15	16	AMOUNT TO USE FOR RATE CALCULATION	\$	16
FOR BHF USE ONLY																							
13	FROM R. E. TAX STATEMENT FOR 2006	\$	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:** 2006 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 2006 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2006.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2006 real estate tax bill to Healthcare and Family Services, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2007 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.

2006 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME LAKEVIEW LIVING CENTER COUNTY COOK

FACILITY IDPH LICENSE NUMBER 0047811

CONTACT PERSON REGARDING THIS REPORT _____

TELEPHONE () _____ FAX #: () _____

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2006 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 2006.

(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. <u>N/A</u>	_____	\$ _____	\$ _____
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 2006 tax bills which were listed in Section A to this statement. Be sure to use the 2006 tax bill which is normally paid during 2007.

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

Facility Name & ID Number LAKEVIEW LIVING CENTER

0047811 Report Period Beginning:

07/01/2006 Ending: 06/30/2007

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>	1
2					2
3	TOTALS	26,080		\$ 41,516	3

Facility Name & ID Number LAKEVIEW LIVING CENTER

0047811

Report Period Beginning:

07/01/2006 Ending: 06/30/2007

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	\$	\$ 841,980	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		8,704	16
17		BUILDING IMPROVEMENT		1993	112,022	7,468	15	7,468		106,732	17
18		BUILDING IMPROVEMENT		1993	115,471	7,698	15	7,698		103,924	18
19		BUILDING IMPROVEMENT		1994			10				19
20		BUILDING IMPROVEMENT		1995	32,918	2,195	15	2,195		27,010	20
21		INSTALL FIRE HOUSE		1995	1,228	82	15	82		949	21
22		ELEVATOR IMPROVEMENTS		1996	3,356	224	15	224		2,537	22
23		RECEPTION AREA		1996	1,598	107	15	107		1,198	23
24		TWO SETS OF STEEL DOORS		1995	3,250	217	15	217		2,528	24
25		CABINETS IN RECEPTION AREA		1995	3,500	233	15	233		2,702	25
26		MOTOR FOR ELEVATOR		1996	2,042	136	15	136		1,486	26
27		TUB RESURFACING		1996	4,900	327	15	327		3,539	27
28		CONCRETE RAMP		1996	700	46	15	46		502	28
29		ROOF SHAFT & EXHAUST		1996	1,110	74	15	74		796	29
30		FLOOR DRAIN		1997	2,300	153	15	153		1,584	30
31		BOX ELEVATOR		1997	1,950	130	15	130		1,322	31
32		CONCRETE LUNCH AREA		1997	4,313	286	15	286		2,923	32
33		ROOF WORK		1997	45,658	3,044	15	3,044		30,946	33
34		BOX ON ELEVATOR		1998	525	35	15	35		347	34
35		LIGHTING		1998	2,715	181	15	181		1,765	35
36		PLUMBING		1998	700	47	15	47		443	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:

07/01/2006 Ending: 06/30/2007

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	\$	\$ 1,654	37
38	ROOF TOP EXHAUST FAN	1998	635	42	15	42		406	38
39	ELECTRIC DOOR STRIKE	1998	582	39	15	39		385	39
40	GLASS	1998	679	45	15	45		445	40
41	CARPET	1999	518	35	15	35		291	41
42	DOOR	1999	680	45	15	45		348	42
43	BATHROOM RENOVATIONS	2000	8,800	587	15	587		3,850	43
44	PLUMBING	2001	2,100	140	15	140		863	44
45	SHOWER BASE AND TILES	2001	2,200	147	15	147		880	45
46	TUCK POINTING BRICK	2001	43,284	2,886	15	2,886		16,592	46
47	STEEL DOORS	2002	1,430	95	15	95		516	47
48	RESURFACE BATHTUB	2002	1,120	75	15	75		398	48
49	WATER LINE MOTOR	2002	1,275	85	15	85		446	49
50	ELEVATOR EDGE	2001	1,696	113	15	113		669	50
51	ELEVATOR DOORS	2002	920	61	15	61		332	51
52	WATER LINE	2002	1,750	117	15	117		593	52
53	HOPKINS ELEVATOR REPAIR	2004	1,009	67	15	67		247	53
54	DURAGLAZE TUB REFURNISHING	2004	2,845	190	15	190		601	54
55	ROOF REPAIRS	2004	1,050	70	15	70		210	55
56	FLOORING	2004	2,928	195	15	195		585	56
57	WINDOWS	2004	1,885	126	15	126		346	57
58	ELEVATOR REPAIRS	2004	1,480	99	15	99		272	58
59	ELEVATOR DRIVE UNIT	2005	4,273	285	15	285		522	59
60	EXTERINAL CABLE SETUP	2005	1,264	84	15	84		154	60
61	NEW WINDOWS	2005	560	37	15	37		68	61
62	TUB RESURFACING	2005	3,505	234	15	234		370	62
63	NEW ELEVATOR GENERATOR	2006	5,324	355	15	355		384	63
64	ELEVATOR KEY LOCK	2006	2,326	155	15	155		155	64
65	WATER CIRCULATION REPAIR	2006	680	45	15	45		45	65
66	REPLACE ELEVATOR MOTOR	2006	4,569	203	15	203		203	66
67	SITE GAURDS ELEVATOR	2006	1,489	54	15	54		54	67
68	CIRCULATING PUMP	2007	1,030	34	15	34		34	68
69									69
70	TOTAL (lines 4 thru 69)		\$ 2,340,585	\$ 75,520		\$ 75,520	\$	\$ 1,475,628	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	\$ 501,036	\$ 50,489	\$ 50,489	\$	5-10 YRS	\$ 280,875	71
72	Current Year Purchases	23,148	1,606	1,606		5-10 YRS	1,606	72
73	Fully Depreciated Assets	628,194	250	250		5-10 YRS	628,194	73
74	ALLOCATED FROM PARENT		14,192	14,192				74
75	TOTALS	\$ 1,152,378	\$ 66,537	\$ 66,537	\$		\$ 910,675	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	\$ 4,398	\$ 4,398	\$	5	\$ 23,986	76
77	RESIDENT TRANSPORTA	2003 FORD VAN	2003	24,501	4,900	4,900		5	20,010	77
78	RESIDENT TRANSPORTA	2004 CHEVY VENTURE	2004	18,511	3,702	3,702		5	11,106	78
79										79
80	TOTALS			\$ 66,998	\$ 13,000	\$ 13,000	\$		\$ 55,102	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)	\$ 3,601,477	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 155,057	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 155,057	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)	\$ 2,441,405	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: 07/01/2006

Ending: 06/30/2007

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: _____

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? _____

If NO, see instructions.

YES NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$ _____			3
4	Additions				_____			4
5	SEE SCH 6A				9,026			5
6					_____			6
7	TOTAL				\$ 9,026			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.	_____ /2008	\$ _____
13.	_____ /2009	\$ _____
14.	_____ /2010	\$ _____

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: \$ 4,642 Description: SEE SCH 6A \$604, COPIER \$1104, DISHWASHER \$2400, POSTAGE MACHINE \$534

(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	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.

Facility Name & ID Number LAKEVIEW LIVING CENTER

0047811

Report Period Beginning: 07/01/2006

Ending:

06/30/2007

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 06/30/2007

(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	37,600		2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance 114,833)	1,386,379		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	438		6
7	Other Prepaid Expenses	780		7
8	Accounts Receivable (owners or related parties)	4,619,902		8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 6,046,599	\$	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	754,601		15
16	Equipment, at Historical Cost	1,219,376		16
17	Accumulated Depreciation (book methods)	(2,441,405)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	415,247		21
22	Other Long-Term Assets (specify):			22
23	Other(specify):	61,080		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,636,399	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 7,682,998	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 459,930	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	37,600		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	121,240		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	59,199		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)	\$ 677,969	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	7,584		39
40	Mortgage Payable	2,351,739		40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 2,359,323	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 3,037,292	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 4,645,706	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 7,682,998	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 4,320,429	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 4,320,429	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	325,277	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)	\$ 325,277	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)	\$ 4,645,706	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number LAKEVIEW LIVING CENTER

0047811

Report Period Beginning: 07/01/2006

Ending: 06/30/2007

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	\$ 4,506,412	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,506,412	3
B. Ancillary Revenue			
4	Day Care	1,108,121	4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,108,121	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space	1,266	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)	\$ 1,266	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	43,496	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 43,496	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)	\$ 5,659,295	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	764,504	31
32	Health Care	2,097,276	32
33	General Administration	678,052	33
B. Capital Expense			
34	Ownership	315,995	34
C. Ancillary Expense			
35	Special Cost Centers	1,146,071	35
36	Provider Participation Fee	332,120	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 5,334,018	40
41	Income before Income Taxes (line 30 minus line 40)**	325,277	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 325,277	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: 07/01/2006

Ending:

06/30/2007

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	1,913	2,086	\$ 53,186	\$ 25.50	1
2	Assistant Director of Nursing	2,330	2,591	50,629	19.54	2
3	Registered Nurses					3
4	Licensed Practical Nurses	12,126	13,019	253,169	19.45	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	1,527	1,767	17,497	9.90	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	18,607	19,947	205,945	10.32	15
16	Dishwashers					16
17	Maintenance Workers	4,088	4,396	58,515	13.31	17
18	Housekeepers	9,395	10,246	100,828	9.84	18
19	Laundry	4,048	4,613	52,988	11.49	19
20	Administrator	2,190	2,455	81,411	33.16	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	8,712	9,317	105,712	11.35	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)	9,071	9,845	147,555	14.99	28
29	Resident Services Coordinator	1,382	1,416	28,797	20.34	29
30	Habilitation Aides (DD Homes)	107,322	119,169	1,220,923	10.25	30
31	Medical Records	3,700	3,893	30,454	7.82	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	186,411	204,760	\$ 2,407,609 *	\$ 11.76	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	213	\$ 10,566	L1, C3	35
36	Medical Director				36
37	Medical Records Consultant				37
38	Nurse Consultant	25	622	L10, C3	38
39	Pharmacist Consultant	MONTHLY	2,090	L10, C3	39
40	Physical Therapy Consultant	147	8,449	L10A, C3	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	248	12,401	L10A, C3	43
44	Activity Consultant				44
45	Social Service Consultant	596	34,440	L12, C3	45
46	Other(specify) PSYCHOLOGICAL	MONTHLY	48,000	L10, C3	46
47					47
48					48
49	TOTAL (lines 35 - 48)	1,229	\$ 116,568		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	2,726	105,090	L10, C3	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	2,726	\$ 105,090		53

Facility Name & ID Number LAKEVIEW LIVING CENTER

0047811

Report Period Beginning: 07/01/2006

Ending: 06/30/2007

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/RHONDA ROWERY	ADMINISTRATOR	0	\$ 81,411	Workers' Compensation Insurance	\$ (93,358)	IDPH License Fee	\$		
				Unemployment Compensation Insurance	35,885	Advertising: Employee Recruitment	951		
				FICA Taxes	193,468	Health Care Worker Background Check			
				Employee Health Insurance	149,373	(Indicate # of checks performed 76)	760		
				Employee Meals	49,007	Patient Background Checks			
				Illinois Municipal Retirement Fund (IMRF)*		VEHICLE LICENSE	391		
				UNION PENSION FUND	55,050	PARENT ALLOC	2,422		
				EMPLOYEE MORAL	7,901	CITY LICENSE/PERMITS	2,606		
						MES/MAG. SUBSCRIPTIONS	663		
TOTAL (agree to Schedule V, line 17, col. 1)			\$ 81,411			Less: Public Relations Expense	()		
(List each licensed administrator separately.)						Non-allowable advertising	()		
						Yellow page advertising	()		
B. Administrative - Other						TOTAL (agree to Sch. V, line 20, col. 8)		\$ 7,793	
Description			Amount	TOTAL (agree to Schedule V, line 22, col.8)			\$ 397,326		
N/A			\$						
TOTAL (agree to Schedule V, line 17, col. 3)			\$	E. Schedule of Non-Cash Compensation Paid to Owners or Employees					
(Attach a copy of any management service agreement)				Description			Line #	Amount	
C. Professional Services							G. Schedule of Travel and Seminar**		
Vendor/Payee	Type		Amount				Description	Amount	
JONES DAY	LEGAL		\$ 917	N/A			Out-of-State Travel	\$	
LAWRENCE MANSON	LEGAL		4,795						
KRIEG, DEVAULT	LEGAL		7,647						
HEINOLD-BANWART	ACCOUNTING		19,057				In-State Travel		
HEINOLD-BANWART	ACCOUNTING		395				BEST PRACTICES	614	
SCHULER, ROCHE, ZWIRNER	LEGAL		118				COACHING	285	
							MISC SEMINARS	698	
							Seminar Expense		
							IHCA CONVENTION	1,386	
							CLINICAL UPDATES	527	
							Entertainment Expense	()	
TOTAL (agree to Schedule V, line 19, column 3)			\$ 32,929	TOTAL			\$		
(If total legal fees exceed \$5,000, attach copy of invoices.)							TOTAL (agree to Sch. V, line 24, col. 8)		\$ 3,510

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number LAKEVIEW LIVING CENTER

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? 5-15 YRS
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 815 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? NO
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? _____ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 332,120
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. \$ 49,007 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 \$5,000, have legal invoices and a summary of services performed been attached to this cost report? YES
Attach invoices and a summary of services for all architect and appraisal fees.