

Facility Name & ID Number Lakewood Senior Living-Mattoon

0047860 Report Period Beginning: 01/01/07 Ending: 12/31/07

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	148	Skilled (SNF)	148	54,020	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	148	TOTALS	148	54,020	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	Total	
8	SNF	14,245	4,542	6,352	25,139	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	14,245	4,542	6,352	25,139	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 46.54%

D. How many bed-hold days during this year were paid by the Department? 0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)

Outpatient therapy

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 10/01/2005

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

YES Date 10/01/2005 NO

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

YES NO If YES, enter number of beds certified 148 and days of care provided 6,279

Medicare Intermediary WPS Medicare

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

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

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

Facility Name & ID Number Lakewood Senior Living-Mattoon # 0047860 Report Period Beginning: 01/01/07 Ending: 12/31/07

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	149,603	18,077	8,498	176,178		176,178		176,178		1
2	Food Purchase		137,089		137,089		137,089	(3,293)	133,796		2
3	Housekeeping	104,155	18,362		122,517		122,517		122,517		3
4	Laundry	40,795	21,284		62,079		62,079		62,079		4
5	Heat and Other Utilities			129,579	129,579		129,579	(10,973)	118,606		5
6	Maintenance	35,590	16,848	44,981	97,419		97,419		97,419		6
7	Other (specify):*										7
8	TOTAL General Services	330,143	211,660	183,058	724,861		724,861	(14,266)	710,595		8
	B. Health Care and Programs										
9	Medical Director			4,050	4,050		4,050		4,050		9
10	Nursing and Medical Records	1,023,875	103,444	16,563	1,143,882	(3,539)	1,140,343		1,140,343		10
10a	Therapy		2,441	400,621	403,062		403,062		403,062		10a
11	Activities	34,411	5,875	427	40,713		40,713	(2,080)	38,633		11
12	Social Services	25,108		5,567	30,675		30,675		30,675		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,083,394	111,760	427,228	1,622,382	(3,539)	1,618,843	(2,080)	1,616,763		16
	C. General Administration										
17	Administrative	202,871			202,871	(132,879)	69,992		69,992		17
18	Directors Fees										18
19	Professional Services			284,732	284,732	(10,000)	274,732	(2,377)	272,355		19
20	Dues, Fees, Subscriptions & Promotions			25,568	25,568		25,568	(21,690)	3,878		20
21	Clerical & General Office Expenses		18,015	33,236	51,251	132,879	184,130	(2,064)	182,066		21
22	Employee Benefits & Payroll Taxes			283,138	283,138		283,138		283,138		22
23	Inservice Training & Education			2,346	2,346		2,346	(350)	1,996		23
24	Travel and Seminar			1,940	1,940	6,657	8,597	(607)	7,990		24
25	Other Admin. Staff Transportation			9,788	9,788	(6,657)	3,131	(2,062)	1,069		25
26	Insurance-Prop.Liab.Malpractice			141,977	141,977		141,977	(734)	141,243		26
27	Other (specify):*			3,790	3,790		3,790	(3,790)			27
28	TOTAL General Administration	202,871	18,015	786,515	1,007,401	(10,000)	997,401	(33,674)	963,727		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,616,408	341,435	1,396,801	3,354,644	(13,539)	3,341,105	(50,020)	3,291,085		29

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

SEE ACCOUNTANTS' COMPILATION REPORT

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 Lakewood Senior Living-Mattoon #0047860 Report Period Beginning: 01/01/07 Ending: 12/31/07

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclassification 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			12,265	12,265		12,265	189,943	202,208			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			79,677	79,677		79,677	149,475	229,152			32
33	Real Estate Taxes			65,831	65,831		65,831	(9,338)	56,493			33
34	Rent-Facility & Grounds			172,434	172,434	10,000	182,434	(182,434)				34
35	Rent-Equipment & Vehicles			19,198	19,198		19,198		19,198			35
36	Other (specify):*											36
37	TOTAL Ownership			349,405	349,405	10,000	359,405	147,646	507,051			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation					3,539	3,539		3,539			38
39	Ancillary Service Centers		184,105		184,105		184,105		184,105			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			81,030	81,030		81,030		81,030			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		184,105	81,030	265,135	3,539	268,674		268,674			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,616,408	525,540	1,827,236	3,969,184		3,969,184	97,626	4,066,810			45

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lakewood Senior Living-Mattoon

0047860

Report Period Beginning: 01/01/07

Ending: 12/31/07

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
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(3,045)	2		4
5	Telephone, TV & Radio in Resident Rooms	(10,973)	5		5
6	Rented Facility Space				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	(2,813)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(248)	2		13
14	Non-Care Related Interest				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	(2,064)	21		18
19	Entertainment	(2,080)	11		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	(20,686)	20		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 5A	(20,408)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (62,317)		\$	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))	\$ (62,317)		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.	x		\$ 3,539	10	38
39						39
40	Gift and Coffee Shops		x			40
41	Barber and Beauty Shops		x			41
42	Laboratory and Radiology		x			42
43	Prescription Drugs		x			43
44	Exceptional Care Program		x			44
45	Other-Attach Schedule		x			45
46	Other-Attach Schedule		x			46
47	TOTAL (C): (sum of lines 38-46)			\$ 3,539		47

BHF USE ONLY					
48		49		50	51
					52

SEE ACCOUNTANTS' COMPILATION REPORT

Lakewood Senior Living-Mattoon

ID# 0047860

Report Period Beginning: 01/01/07

Ending: 12/31/07

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	Legal fees	\$ (2,377)	19	1
2	Chamber of Commerce Dues	(754)	20	2
3	Dues	(250)	20	3
4	Entertainment	(607)	24	4
5	Unallowable per WTB	(3,790)	27	5
6	Automobile Insurance	(734)	26	6
7	Adjust interest	(146)	32	7
8	Adjust real estate taxes	(9,338)	33	8
9	Travel	(350)	23	9
10	Use tax on Automobile Purchase	(2,062)	25	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	(20,408)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Lakewood Senior Living-Mattoon

0047860

Report Period Beginning:

01/01/07

Ending:

12/31/07

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	(3,293)	0	0	0	0	0	0	0	0	0	0	(3,293)	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	(10,973)	0	0	0	0	0	0	0	0	0	0	(10,973)	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(14,266)	0	0	0	0	0	0	0	0	0	0	(14,266)	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	(2,080)	0	0	0	0	0	0	0	0	0	0	(2,080)	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	(2,080)	0	0	0	0	0	0	0	0	0	0	(2,080)	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	(2,377)	0	0	0	0	0	0	0	0	0	0	(2,377)	19
20	Fees, Subscriptions & Promotions	(21,690)	0	0	0	0	0	0	0	0	0	0	(21,690)	20
21	Clerical & General Office Expenses	(2,064)	0	0	0	0	0	0	0	0	0	0	(2,064)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	(350)	0	0	0	0	0	0	0	0	0	0	(350)	23
24	Travel and Seminar	(607)	0	0	0	0	0	0	0	0	0	0	(607)	24
25	Other Admin. Staff Transportation	(2,062)	0	0	0	0	0	0	0	0	0	0	(2,062)	25
26	Insurance-Prop.Liab.Malpractice	(734)	0	0	0	0	0	0	0	0	0	0	(734)	26
27	Other (specify):*	(3,790)	0	0	0	0	0	0	0	0	0	0	(3,790)	27
28	TOTAL General Administration	(33,674)	0	0	0	0	0	0	0	0	0	0	(33,674)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(50,020)	0	0	0	0	0	0	0	0	0	0	(50,020)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Lakewood Senior Living-Mattoon

0047860

Report Period Beginning:

01/01/07

Ending:

12/31/07

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	189,943	0	0	0	0	0	0	0	0	0	189,943	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(2,959)	152,434	0	0	0	0	0	0	0	0	0	149,475	32
33	Real Estate Taxes	(9,338)	0	0	0	0	0	0	0	0	0	0	(9,338)	33
34	Rent-Facility & Grounds	0	(182,434)	0	0	0	0	0	0	0	0	0	(182,434)	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	(12,297)	159,943	0	147,646	37								
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(62,317)	159,943	0	97,626	45								

Facility Name & ID Number Lakewood Senior Living-Mattoon

0047860

Report Period Beginning:

01/01/07

Ending:

12/31/07

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
Lakewood Hunter Holdings, Inc.	100			Lakewood - Mattoon, IL	Birmingham, AL	Leasing

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	34 Facility Lease	\$ 182,434	Lakewood - Mattoon, LLC	0.00%	\$	\$ (182,434)	1	
2	V	30 Depreciation		Lakewood - Mattoon, LLC	0.00%	189,943	189,943	2	
3	V	32 Interest		Lakewood - Mattoon, LLC	0.00%	152,434	152,434	3	
4	V							4	
5	V	This facility was part of a package of defaulted facilities which the current operator has taken over under a work-out plan. As part of the work-out plan, the debt was non-accrual until May 2007, at which time it began accruing interest at the rate of 5.5% per annum. Rental will accrue at a corresponding rate plus \$2500 per month and amortization.							5
6	V							6	
7	V							7	
8	V							8	
9	V							9	
10	V							10	
11	V							11	
12	V							12	
13	V							13	
14	Total		\$ 182,434			\$ 342,377	\$ * 159,943	14	

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

Facility Name & ID Number Lakewood Senior Living-Mattoon # 0047860 Report Period Beginning: 01/01/07 Ending: 12/31/07

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									\$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		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.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lakewood Senior Living-Mattoon

0047860

Report Period Beginning: 01/01/07

Ending: 12/31/07

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 _____
 Street Address _____
 City / State / Zip Code _____
 Phone Number () _____
 Fax Number () _____

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					\$	\$		\$	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	TOTALS				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

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	First Commercial Bank		X	Van Purchase	\$690.09	5/30/07	\$ 34,096	\$ 31,724	6/05/12	7.7500	\$ 1,342	1								
2	Lakewood BLGA Holdings	X		Time Clock Financing	\$201.81	10/1/06	6,398	4,098	9/30/09	8.5000	441	2								
3	Interest Income Offset										(2,813)	3								
4												4								
5												5								
Working Capital																				
6	Capmark Finance, Inc.		X	W/C - Receivables	Interest only	3/25/05	3,500,000	1,309,803	N/A	7.5700	69,587	6								
7	Survey Companies	X		Working Capital	Interest only	9/27/07	39,183	39,183	9/27/09	7.7500	785	7								
8	Bank Direct Financing		X	Insurance	\$17,631.41	11/1/07	204,223	170,186	10/31/07	4.0000	7,376	8								
9	TOTAL Facility Related				\$18,523.31		\$ 3,783,900	\$ 1,554,994			\$ 76,718	9								
B. Non-Facility Related*																				
10												10								
11												11								
12												12								
13												13								
14	TOTAL Non-Facility Related						\$	\$			\$	14								
15	TOTALS (line 9+line14)						\$ 3,783,900	\$ 1,554,994			\$ 76,718	15								

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ _____ 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.)

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Lakewood Senior Living-Mattoon# 0047860 Report Period Beginning: 01/01/07Ending: 12/31/07

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2006 report.		Important , please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	\$	59,665	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.)			\$	58,079	2
3. Under or (over) accrual (line 2 minus line 1).			\$	(1,586)	3
4. Real Estate Tax accrual used for 2007 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	58,079	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.			\$	56,493	7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:					
2002	_____	8			
2003	_____	9			
2004	_____	10			
2005	59,665	11			
2006	58,079	12			
2007 real estate tax accrual based on amount paid for previous year. Amount paid = 58,079.					
			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:

- Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
- 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.

SEE ACCOUNTANTS' COMPILATION REPORT

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 Lakewood Senior Living-Mattoon COUNTY Coles

FACILITY IDPH LICENSE NUMBER 0047860

CONTACT PERSON REGARDING THIS REPORT Paula Mason

TELEPHONE (217) 235-7140 FAX #: (217) 235-7140

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>07-1-00922-000</u>	<u>Land and Building</u>	\$ <u>58,078.90</u>	\$ <u>58,078.90</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>58,078.90</u>	\$ <u>58,078.90</u>

B. Real Estate Tax Cost Allocations

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

If YES, attach an explanation & 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 Lakewood Senior Living-Mattoon

0047860 Report Period Beginning:

01/01/07 Ending:

12/31/07

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 43,372 B. General Construction Type: Exterior Masonry Frame Steel Number of Stories 1

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).

None

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

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

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>Nursing Facility</u>	<u>217,680</u>	<u>2003</u>	<u>\$ 560,000</u>	<u>1</u>
2					<u>2</u>
3	TOTALS	217,680		\$ 560,000	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lakewood Senior Living-Mattoon

0047860

Report Period Beginning:

01/01/07

Ending:

12/31/07

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	148		2003	1971	\$ 7,408,069	\$ 189,943	39	\$ 189,943	\$	\$ 846,965	4
5											5
6											6
7											7
8											8
Improvement Type**											
9		Roof Covering		11/10/2005	12,430	1,243	10	1,243		2,693	9
10		Building Repairs		1/1/2006	14,530	969	15	969		1,937	10
11		Air Conditioner Unit		3/22/2006	514	103	5	103		180	11
12		Sidewalk and Asphalt Repair		5/2/2006	12,405	827	15	827		1,378	12
13		Fire Alarm		6/1/2006	16,159	1,616	10	1,616		2,559	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

*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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lakewood Senior Living-Mattoon

0047860

Report Period Beginning:

01/01/07

Ending:

12/31/07

XI. OWNERSHIP COSTS (continued)

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

1	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		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67								67
68								68
69								69
70	TOTAL (lines 4 thru 69)	\$ 7,464,107	\$ 194,701		\$ 194,701	\$	\$ 855,712	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Lakewood Senior Living-Mattoon # 0047860 Report Period Beginning: 01/01/07 Ending: 12/31/07

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	\$ 63,801	\$ 3,218	\$ 3,218	\$	5-7 yrs	\$ 13,281	71
72	Current Year Purchases	9,344	259	259		5-10 yrs	259	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 73,145	\$ 3,477	\$ 3,477	\$		\$ 13,540	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	Long-Term Care	2007 Ford E250	2007	\$ 34,547	\$ 4,030	\$ 4,030	\$	5	\$ 4,030	76
77										77
78										78
79										79
80	TOTALS			\$ 34,547	\$ 4,030	\$ 4,030	\$		\$ 4,030	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)	\$ 8,131,799	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 202,208	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 202,208	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)	\$ 873,282	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.

SEE ACCOUNTANTS' COMPILATION REPORT

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					_____			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.	_____ /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: \$ _____ Description: _____

(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.

Facility Name & ID Number Lakewood Senior Living-Mattoon # 0047860 Report Period Beginning: 01/01/07 Ending: 12/31/07

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.
- SEE ACCOUNTANTS' COMPILATION REPORT

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	10A-3	hrs	\$	2,336	\$ 144,102	\$ 441	2,336	\$ 144,543	1
2	Licensed Speech and Language Development Therapist	10A-3	hrs		1,147	62,006	29	1,147	62,035	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A-3	hrs		3,378	194,158	815	3,378	194,973	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescrpts		10,885		151,087	10,885	151,087	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			\$	17,746	\$ 400,266	\$ 152,372	17,746	\$ 552,638	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.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lakewood Senior Living-Mattoon

0047860

Report Period Beginning: 01/01/07

Ending:

12/31/07

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/07

(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	\$ 82,052	\$	1
2	Cash-Patient Deposits	9,841		2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	1,150,817		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	158,683		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Interest Receivable</u>	991		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,402,384	\$	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	56,038		15
16	Equipment, at Historical Cost	107,693		16
17	Accumulated Depreciation (book methods)	(22,288)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 141,443	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,543,827	\$	25

		1 Operating	2 After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 258,562	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	9,841		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	71,109		30
31	Accrued Taxes Payable (excluding real estate taxes)	15,008		31
32	Accrued Real Estate Taxes(Sch.IX-B)	58,079		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	<u>Accrued Insurance</u>	985		36
37	<u>Due to Medicaid</u>	199,779		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 613,363	\$	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable	1,399,344		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
Other Long-Term Liabilities(specify):				
43	<u>A/P Affiliated</u>	262,851		43
44	<u>N/P Lakewood BGLA Holding</u>	4,098		44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 1,666,293	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 2,279,656	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ (735,829)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,543,827	\$	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (681,329)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (681,329)	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(54,498)	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) Rounding	(2)	15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (54,500)	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)	\$ (735,829)	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lakewood Senior Living-Mattoon

0047860

Report Period Beginning: 01/01/07

Ending: 12/31/07

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	\$ 3,117,002	1
2	Discounts and Allowances for all Levels	(390,072)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,726,930	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	888,357	6
7	Oxygen	20,873	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 909,230	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	3,045	14
15	Telephone, Television and Radio	2,210	15
16	Rental of Facility Space		16
17	Sale of Drugs	210,198	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	8,993	19
20	Radiology and X-Ray	3,098	20
21	Other Medical Services	48,167	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 275,711	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	2,813	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 2,813	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)	\$ 3,914,684	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	724,861	31
32	Health Care	1,622,382	32
33	General Administration	1,007,400	33
B. Capital Expense			
34	Ownership	349,404	34
C. Ancillary Expense			
35	Special Cost Centers	184,105	35
36	Provider Participation Fee	81,030	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 3,969,182	40
41	Income before Income Taxes (line 30 minus line 40)**	(54,498)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (54,498)	43

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? Not Complete 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. SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Lakewood Senior Living-Mattoon

0047860

Report Period Beginning:

01/01/07

Ending:

12/31/07

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	1,896	2,080	\$ 59,333	\$ 28.53	1
2	Assistant Director of Nursing	1,939	2,083	43,386	20.83	2
3	Registered Nurses	4,872	5,152	124,171	24.10	3
4	Licensed Practical Nurses	13,276	14,375	268,785	18.70	4
5	CNAs & Orderlies	48,463	52,104	528,200	10.14	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,027	2,248	34,411	15.31	9
10	Activity Assistants					10
11	Social Service Workers	1,819	1,920	25,108	13.08	11
12	Dietician					12
13	Food Service Supervisor	1,782	1,945	19,484	10.02	13
14	Head Cook					14
15	Cook Helpers/Assistants	14,574	16,292	130,119	7.99	15
16	Dishwashers					16
17	Maintenance Workers	2,048	2,152	35,590	16.54	17
18	Housekeepers	10,849	11,657	104,155	8.93	18
19	Laundry	5,353	5,827	40,795	7.00	19
20	Administrator	1,904	2,080	69,992	33.65	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	7,630	8,669	132,879	15.33	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	118,432	128,584	\$ 1,616,408 *	\$ 12.57	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	207	\$ 8,498	1-3	35
36	Medical Director	Monthly	4,050	9-3	36
37	Medical Records Consultant	20	1,170	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	4,440	10-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	227	\$ 18,158		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	24	\$ 1,794	10-3	50
51	Licensed Practical Nurses	69	2,847	10-3	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	93	\$ 4,641		53

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lakewood Senior Living-Mattoon

0047860

Report Period Beginning: 01/01/07

Ending: 12/31/07

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
<u>Alma Boyer</u>	<u>Administrator</u>		\$ <u>69,992</u>	<u>Workers' Compensation Insurance</u>	\$ <u>53,900</u>	<u>IDPH License Fee</u>	\$ <u>3,671</u>
				<u>Unemployment Compensation Insurance</u>	<u>46,029</u>	<u>Advertising: Employee Recruitment</u>	
				<u>FICA Taxes</u>	<u>119,173</u>	<u>Health Care Worker Background Check</u>	
				<u>Employee Health Insurance</u>	<u>61,849</u>	(Indicate # of checks performed _____)	
				<u>Employee Meals</u>		<u>Patient Background Checks</u>	
				<u>Illinois Municipal Retirement Fund (IMRF)*</u>		<u>Professional dues</u>	<u>207</u>
				<u>Employee Physicals</u>	<u>1,400</u>		
				<u>Employee Activities</u>	<u>787</u>		
TOTAL (agree to Schedule V, line 17, col. 1)			\$ <u>69,992</u>	TOTAL (agree to Schedule V, line 22, col.8)		\$ <u>3,878</u>	
B. Administrative - Other						Less: Public Relations Expense ()	
Description			Amount			Non-allowable advertising ()	
			\$ _____			Yellow page advertising ()	

TOTAL (agree to Schedule V, line 17, col. 3)			\$ _____			TOTAL (agree to Sch. V, line 20, col. 8)	
(Attach a copy of any management service agreement)							
C. Professional Services			E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Vendor/Payee	Type	Amount	Description	Line #	Amount	Description	Amount
<u>American Healthtech</u>	<u>Data Processing</u>	\$ <u>17,240</u>			\$ _____	<u>Out-of-State Travel</u>	\$ _____
<u>Prime Care Technologies</u>	<u>Data Processing</u>	<u>10,898</u>			_____		
<u>Mutual of Omaha</u>	<u>Data Processing</u>	<u>298</u>			_____		
<u>Claude Estes & Co</u>	<u>Accounting</u>	<u>1,222</u>			_____	<u>In-State Travel</u>	
<u>Jan-Jenkins Ardovino</u>	<u>Accounting</u>	<u>523</u>			_____	<u>Administrative Travel Reimbursement</u>	<u>7,990</u>
<u>Williams Anderson</u>	<u>Contractual Service</u>	<u>254</u>			_____		
<u>Self, Maples & Copeland, PC</u>	<u>Accounting</u>	<u>30,262</u>			_____	<u>Seminar Expense</u>	
<u>Johnston, Barton & Proctor</u>	<u>Legal Services</u>	<u>4,758</u>			_____		
<u>Prism Healthcare Group</u>	<u>Management Fees</u>	<u>206,900</u>			_____		

TOTAL (agree to Schedule V, line 19, column 3)			\$ <u>272,355</u>	TOTAL		Entertainment Expense ()	
(If total legal fees exceed \$5,000, attach copy of invoices.)						(agree to Sch. V, line 24, col. 8)	
						\$ <u>7,990</u>	

* Attach copy of IMRF notifications
SEE ACCOUNTANTS' COMPILATION REPORT

**See instructions.

Facility Name & ID Number Lakewood Senior Living-Mattoon

Report Period Beginning: 01/01/07 Ending:

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1 Improvement Type	2 Month & Year Improvement Was Made	3 Total Cost	4 Useful Life	Amount of Expense Amortized Per Year								
					5 FY2004	6 FY2005	7 FY2006	8 FY2007	9 FY2008	10 FY2009	11 FY2010	12 FY2011	13 FY2012
1			\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lakewood Senior Living-Mattoon

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? No
If YES, give association name and amount. _____
- (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? _____
- (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 years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 2,700 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. _____
- (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. \$ 81,030
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. \$ 0 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 3,045
- (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? _____ If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? _____
d. Have vehicle usage logs been 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? Yes
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ _____
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: _____ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? _____ 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? N/A
Attach invoices and a summary of services for all architect and appraisal fees.

SEE ACCOUNTANTS' COMPILATION REPORT

Detail of Schedule V Line 24

Mileage reimbursement provided to employees for business related travel. Reimbursement provided at 44.5 cents per mile for miles driven. Employees turn in mileage reimbursement requests. Total amount of reimbursement in line 24 = \$7,990.

Schedule of Schedule V Reclassifications

- 1 On line 10 - reclassified \$3539 of medically necessary transportation costs to line 38.
- 2 On line 17 - reclassified \$132,879 of salaries related to clerical staff to line 21.
- 3 On line 19 - reclassified \$10,000 of lease expense to line 34-3.
- 4 On line 24 - reclassified \$6,657 of administrative travel reimbursement costs to line 23.