

Facility Name & ID Number LAKEVIEW LIVING CENTER# 0047811 Report Period Beginning: 07/01/2007 Ending: 06/30/2008

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4	<u>145</u>	Intermediate/DD	<u>145</u>	<u>53,070</u>	4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>145</u>	TOTALS	<u>145</u>	<u>53,070</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment			
		Medicaid Recipient	Private Pay	Other	
8	SNF				8
9	SNF/PED				9
10	ICF				10
11	ICF/DD	<u>26,724</u>	<u>366</u>		<u>27,090</u>
12	SC				12
13	DD 16 OR LESS				13
14	TOTALS	<u>26,724</u>	<u>366</u>		<u>27,090</u>

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 51.05%

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

285 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.

(E.g., day care, "meals on wheels", outpatient therapy)

NONEF. Does the facility maintain a daily midnight census? YESG. Do pages 3 & 4 include expenses for services or
investments not directly related to patient care?YES NO

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES NO

I. On what date did you start providing long term care at this location?

Date started 05/23/1983

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

YES Date 12/01/1988 NO

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

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

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH* Is your fiscal year identical to your tax year? YES NO Tax Year: 06/30/2008 Fiscal Year: 06/30/2008

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

Facility Name & ID Number LAKEVIEW LIVING CENTER # 0047811 Report Period Beginning: 07/01/2007 Ending: 06/30/2008

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	182,755	17,130	11,532	211,417		211,417		211,417		1
2	Food Purchase		109,176		109,176		109,176		109,176		2
3	Housekeeping	84,655	19,366		104,021		104,021	1,349	105,370		3
4	Laundry	56,499	10,028	1,190	67,717		67,717		67,717		4
5	Heat and Other Utilities			128,460	128,460		128,460	5,205	133,665		5
6	Maintenance	47,627		37,577	85,204		85,204	1,636	86,840		6
7	Other (specify):*										7
8	TOTAL General Services	371,536	155,700	178,759	705,995		705,995	8,190	714,185		8
	B. Health Care and Programs										
9	Medical Director										9
10	Nursing and Medical Records	1,570,581	38,415	181,011	1,790,007		1,790,007	(2,852)	1,787,155		10
10a	Therapy			14,984	14,984		14,984		14,984		10a
11	Activities		2,981		2,981		2,981		2,981		11
12	Social Services	22,056		17,325	39,381		39,381		39,381		12
13	CNA Training										13
14	Program Transportation			23,649	23,649		23,649		23,649		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,592,637	41,396	236,969	1,871,002		1,871,002	(2,852)	1,868,150		16
	C. General Administration										
17	Administrative	72,668			72,668		72,668		72,668		17
18	Directors Fees			14,675	14,675		14,675	(842)	13,833		18
19	Professional Services			44,565	44,565		44,565	(2,528)	42,037		19
20	Dues, Fees, Subscriptions & Promotions			2,931	2,931		2,931	2,136	5,067		20
21	Clerical & General Office Expenses	113,010	7,372	32,214	152,596		152,596	223,402	375,998		21
22	Employee Benefits & Payroll Taxes			340,171	340,171		340,171	38,433	378,604		22
23	Inservice Training & Education			16,461	16,461		16,461	10,926	27,387		23
24	Travel and Seminar			2,756	2,756		2,756	1,340	4,096		24
25	Other Admin. Staff Transportation			7,700	7,700		7,700		7,700		25
26	Insurance-Prop.Liab.Malpractice			26,087	26,087		26,087	6,452	32,539		26
27	Other (specify):*										27
28	TOTAL General Administration	185,678	7,372	487,560	680,610		680,610	279,319	959,929		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,149,851	204,468	903,288	3,257,607		3,257,607	284,657	3,542,264		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: 07/01/2007 Ending: 06/30/2008

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			131,792	131,792	131,792	10,863	142,655			30
31	Amortization of Pre-Op. & Org.										31
32	Interest			165,245	165,245	165,245	(33,646)	131,599			32
33	Real Estate Taxes										33
34	Rent-Facility & Grounds						8,474	8,474			34
35	Rent-Equipment & Vehicles			2,963	2,963	2,963	440	3,403			35
36	Other (specify):*										36
37	TOTAL Ownership			300,000	300,000	300,000	(13,869)	286,131			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			258,360	258,360	258,360		258,360			42
43	Other (specify):*			932,963	932,963	932,963	(932,963)				43
44	TOTAL Special Cost Centers			1,191,323	1,191,323	1,191,323	(932,963)	258,360			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,149,851	204,468	2,394,611	4,748,930	4,748,930	(662,175)	4,086,755			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: 07/01/2007

Ending: 06/30/2008

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	\$ (917,283)	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	(682)	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	(31,310)	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	(4,278)	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees	(13,557)	43		17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(377)	32		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(15,500)	43		24
25	Fund Raising, Advertising and Promotional	(180)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (983,167)		\$	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))	\$ (983,167)		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.

		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						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: 07/01/2007
Ending: 06/30/2008

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:

07/01/2007

Ending:

06/30/2008

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	236	110	334	395	274	1,349	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	811	384	1,139	2,256	615	5,205	5
6	Maintenance	(682)	0	0	0	0	0	238	218	649	715	498	1,636	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(682)	0	0	0	0	0	1,285	712	2,122	3,366	1,387	8,190	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	(2,038)	25	(214)	883	(1,508)	(2,852)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	0	0	0	0	0	(2,038)	25	(214)	883	(1,508)	(2,852)	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	(26)	(31)	(113)	(361)	(311)	0	0	0	0	0	(842)	18
19	Professional Services	0	40	(75)	(1,016)	(1,176)	(301)	0	0	0	0	0	(2,528)	19
20	Fees, Subscriptions & Promotions	0	(1)	0	0	0	0	24	91	1,575	425	22	2,136	20
21	Clerical & General Office Expenses	0	(3)	(6)	(214)	(349)	(180)	38,281	18,026	56,591	78,040	33,216	223,402	21
22	Employee Benefits & Payroll Taxes	0	0	0	(123)	(7)	(41)	5,067	3,480	10,416	13,423	6,218	38,433	22
23	Inservice Training & Education	0	1	(2)	(86)	(55)	(42)	2,206	797	2,895	3,038	2,174	10,926	23
24	Travel and Seminar	0	0	0	0	0	0	0	315	863	0	162	1,340	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	1,102	537	1,602	2,095	1,116	6,452	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	0	11	(114)	(1,552)	(1,948)	(875)	46,680	23,246	73,942	97,021	42,908	279,319	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(682)	11	(114)	(1,552)	(1,948)	(875)	45,927	23,983	75,850	101,270	42,787	284,657	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number LAKEVIEW LIVING CENTER

0047811

Report Period Beginning:

07/01/2007 Ending:

06/30/2008

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	0	0	0	0	0	0	1,919	971	2,879	3,951	1,143	10,863	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(35,965)	0	0	0	(37)	815	270	131	382	40	718	(33,646)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	1,387	679	2,108	2,673	1,627	8,474	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	110	0	112	110	108	440	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(35,965)	0	0	0	(37)	815	3,686	1,781	5,481	6,774	3,596	(13,869)	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):*	(946,520)	0	0	0	0	0	652	727	4,984	4,851	2,343	(932,963)	43
44	TOTAL Special Cost Centers	(946,520)	0	0	0	0	0	652	727	4,984	4,851	2,343	(932,963)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(983,167)	11	(114)	(1,552)	(1,985)	(60)	50,265	26,491	86,315	112,895	48,726	(662,175)	45

Facility Name & ID Number LAKEVIEW LIVING CENTER

0047811

Report Period Beginning: 07/01/2007 Ending: 06/30/2008

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)		
<u>1</u>	<u>V</u>	<u>18</u>	<u>BOARD FEES</u>	<u>\$ 2,509</u>	<u>PROGRESSIVE HOUSING, INC.</u>	<u>100.00%</u>	<u>\$ 2,483</u>	<u>(\$ 26)</u>	<u>1</u>
<u>2</u>	<u>V</u>	<u>19</u>	<u>PROFESSIONAL FEES</u>	<u>2,691</u>	<u>PROGRESSIVE HOUSING, INC.</u>	<u>100.00%</u>	<u>2,731</u>	<u>40</u>	<u>2</u>
<u>3</u>	<u>V</u>	<u>20</u>	<u>LICENSE, DUES</u>	<u>2</u>	<u>PROGRESSIVE HOUSING, INC.</u>	<u>100.00%</u>	<u>1</u>	<u>(1)</u>	<u>3</u>
<u>4</u>	<u>V</u>	<u>21</u>	<u>GENERAL OFFICE</u>	<u>1,300</u>	<u>PROGRESSIVE HOUSING, INC.</u>	<u>100.00%</u>	<u>1,297</u>	<u>(3)</u>	<u>4</u>
<u>5</u>	<u>V</u>	<u>23</u>	<u>INSERVICE TRAVEL</u>	<u>273</u>	<u>PROGRESSIVE HOUSING, INC.</u>	<u>100.00%</u>	<u>274</u>	<u>1</u>	<u>5</u>
<u>6</u>	<u>V</u>	<u>32</u>	<u>INTEREST</u>		<u>PROGRESSIVE HOUSING, INC.</u>	<u>100.00%</u>			<u>6</u>
<u>7</u>	<u>V</u>	<u>32</u>	<u>INTEREST INCOME</u>		<u>PROGRESSIVE HOUSING, INC.</u>	<u>100.00%</u>			<u>7</u>
<u>8</u>	<u>V</u>	<u>22</u>	<u>EMPLOYEE BENEFITS</u>		<u>PROGRESSIVE HOUSING, INC.</u>	<u>100.00%</u>			<u>8</u>
<u>9</u>	<u>V</u>								<u>9</u>
<u>10</u>	<u>V</u>								<u>10</u>
<u>11</u>	<u>V</u>								<u>11</u>
<u>12</u>	<u>V</u>								<u>12</u>
<u>13</u>	<u>V</u>								<u>13</u>
<u>14</u>	Total		\$ 6,775				\$ 6,786	\$ *	11

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

Facility Name & ID Number LAKEVIEW LIVING CENTER

0047811

Report Period Beginning: 07/01/2007

Ending: 06/30/2008

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	18 BOARD FEES	\$ 1,004	PROGRESSIVE HOUSING, INC.	100.00%	\$ 973	\$ (31)	15	
16	V	19 PROFESSIONAL FEES	13,039	PROGRESSIVE HOUSING, INC.	100.00%	12,964	(75)	16	
17	V	20 LICENSE, DUES		PROGRESSIVE HOUSING, INC.	100.00%			17	
18	V	21 GENERAL OFFICE	1,110	PROGRESSIVE HOUSING, INC.	100.00%	1,104	(6)	18	
19	V	23 INSERVICE TRAVEL	81	PROGRESSIVE HOUSING, INC.	100.00%	79	(2)	19	
20	V	32 INTEREST		PROGRESSIVE HOUSING, INC.	100.00%			20	
21	V	32 INTEREST INCOME		PROGRESSIVE HOUSING, INC.	100.00%			21	
22	V	22 EMPLOYEE BENEFITS		PROGRESSIVE HOUSING, INC.	100.00%			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		\$ 15,234			\$ 15,120	\$ *	(114)	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: 07/01/2007

Ending: 06/30/2008

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	18 BOARD FEES	\$ 2,258	PROGRESSIVE HOUSING, INC.	100.00%	\$ 2,145	\$ (113)	15	
16	V	19 PROFESSIONAL FEES	9,925	PROGRESSIVE HOUSING, INC.	100.00%	8,909	(1,016)	16	
17	V	20 LICENSE, DUES	5	PROGRESSIVE HOUSING, INC.	100.00%	5		17	
18	V	21 GENERAL OFFICE	2,314	PROGRESSIVE HOUSING, INC.	100.00%	2,100	(214)	18	
19	V	23 INSERVICE TRAVEL	1,024	PROGRESSIVE HOUSING, INC.	100.00%	938	(86)	19	
20	V	32 INTEREST		PROGRESSIVE HOUSING, INC.	100.00%			20	
21	V	32 INTEREST INCOME		PROGRESSIVE HOUSING, INC.	100.00%			21	
22	V	22 EMPLOYEE BENEFITS	1,616	PROGRESSIVE HOUSING, INC.	100.00%	1,493	(123)	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		\$ 17,142			\$ 15,590	\$ *	(1,552)	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: 07/01/2007

Ending: 06/30/2008

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	18 BOARD FEES	\$ 5,153	PROGRESSIVE HOUSING, INC.	100.00%	\$ 4,792	\$ (361)	15
16	V	19 PROFESSIONAL FEES	14,026	PROGRESSIVE HOUSING, INC.	100.00%	12,850	(1,176)	16
17	V	20 LICENSE, DUES		PROGRESSIVE HOUSING, INC.	100.00%			17
18	V	21 GENERAL OFFICE	4,267	PROGRESSIVE HOUSING, INC.	100.00%	3,918	(349)	18
19	V	23 INSERVICE TRAVEL	648	PROGRESSIVE HOUSING, INC.	100.00%	593	(55)	19
20	V	32 INTEREST	481	PROGRESSIVE HOUSING, INC.	100.00%	444	(37)	20
21	V	32 INTEREST INCOME		PROGRESSIVE HOUSING, INC.	100.00%			21
22	V	22 EMPLOYEE BENEFITS	101	PROGRESSIVE HOUSING, INC.	100.00%	94	(7)	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		\$ 24,676			\$ 22,691	\$ * (1,985)	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: 07/01/2007 Ending: 06/30/2008

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	18 BOARD FEES	\$ 3,751	PROGRESSIVE HOUSING, INC.	100.00%	\$ 3,440	\$ (311)	15	
16	V	19 PROFESSIONAL FEES	4,133	PROGRESSIVE HOUSING, INC.	100.00%	3,832	(301)	16	
17	V	20 LICENSE, DUES		PROGRESSIVE HOUSING, INC.	100.00%			17	
18	V	21 GENERAL OFFICE	2,332	PROGRESSIVE HOUSING, INC.	100.00%	2,152	(180)	18	
19	V	23 INSERVICE TRAVEL	552	PROGRESSIVE HOUSING, INC.	100.00%	510	(42)	19	
20	V	32 INTEREST	231	PROGRESSIVE HOUSING, INC.	100.00%	214	(17)	20	
21	V	32 INTEREST INCOME	(11,668)	PROGRESSIVE HOUSING, INC.	100.00%	(10,836)	832	21	
22	V	22 EMPLOYEE BENEFITS	522	PROGRESSIVE HOUSING, INC.	100.00%	481	(41)	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		\$ (147)			\$ (207)	\$ *	(60)	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: 07/01/2007 Ending: 06/30/2008

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.			15
16	V	19 PROFESSIONAL FEES		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.			16
17	V	20 DUES, FEES		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	24	24	17
18	V	22 EMPLOYEE BENEFITS		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	5,067	5,067	18
19	V	23 INSERVICE EDUCATION		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	2,206	2,206	19
20	V	24 TRAVEL SEMINAR		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.			20
21	V	26 INSURANCE		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	1,102	1,102	21
22	V	30 DEPRECIATION		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	1,919	1,919	22
23	V	32 INTEREST		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	285	285	23
24	V	34 RENT		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	1,387	1,387	24
25	V	35 EQUIPMENT RENTAL		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	110	110	25
26	V	5 UTILITIES		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	811	811	26
27	V	6 MAINTENANCE		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	238	238	27
28	V	43 NONALLOWABLE		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	652	652	28
29	V	32 MISC INCOME		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	(15)	(15)	29
30	V	3 HOUSEKEEPING		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	236	236	30
31	V	21 OFFICE		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	38,281	38,281	31
32	V	10 NURSING SUPPLIES		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	(2,038)	(2,038)	32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$ 50,265	\$ * 50,265	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: 07/01/2007 Ending: 06/30/2008

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.			15	
16	V	19 PROFESSIONAL FEES		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.			16	
17	V	20 DUES, FEES		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	91	91	17	
18	V	22 EMPLOYEE BENEFITS		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	3,480	3,480	18	
19	V	23 INSERVICE EDUCATION		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	797	797	19	
20	V	24 TRAVEL SEMINAR		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	315	315	20	
21	V	26 INSURANCE		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	537	537	21	
22	V	30 DEPRECIATION		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	971	971	22	
23	V	32 INTEREST		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	131	131	23	
24	V	34 RENT		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	679	679	24	
25	V	35 EQUIPMENT RENTAL		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.			25	
26	V	5 UTILITIES		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	384	384	26	
27	V	6 MAINTENANCE		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	218	218	27	
28	V	43 NONALLOWABLE		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	727	727	28	
29	V	32 MISC INCOME		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.			29	
30	V	3 HOUSEKEEPING		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	110	110	30	
31	V	21 OFFICE		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	18,026	18,026	31	
32	V	10 NURSING SUPPLIES		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	25	25	32	
33	V							33	
34	V							34	
35	V							35	
36	V							36	
37	V							37	
38	V							38	
39	Total		\$			\$ 26,491	\$ *	26,491	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: 07/01/2007

Ending: 06/30/2008

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.			15	
16	V	19 PROFESSIONAL FEES		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.			16	
17	V	20 DUES, FEES		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	1,575	1,575	17	
18	V	22 EMPLOYEE BENEFITS		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	10,416	10,416	18	
19	V	23 INSERVICE EDUCATION		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	2,895	2,895	19	
20	V	24 TRAVEL SEMINAR		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	863	863	20	
21	V	26 INSURANCE		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	1,602	1,602	21	
22	V	30 DEPRECIATION		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	2,879	2,879	22	
23	V	32 INTEREST		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	382	382	23	
24	V	34 RENT		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	2,108	2,108	24	
25	V	35 EQUIPMENT RENTAL		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	112	112	25	
26	V	5 UTILITIES		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	1,139	1,139	26	
27	V	6 MAINTENANCE		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	649	649	27	
28	V	43 NONALLOWABLE		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	4,984	4,984	28	
29	V	32 MISC INCOME		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.			29	
30	V	3 HOUSEKEEPING		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	334	334	30	
31	V	21 OFFICE		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	56,591	56,591	31	
32	V	10 NURSING SUPPLIES		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	(214)	(214)	32	
33	V							33	
34	V							34	
35	V							35	
36	V							36	
37	V							37	
38	V							38	
39	Total		\$			\$ 86,315	\$ *	86,315	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: 07/01/2007

Ending: 06/30/2008

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.			15
16	V	19 PROFESSIONAL FEES		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.			16
17	V	20 DUES, FEES		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	425	425	17
18	V	22 EMPLOYEE BENEFITS		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	13,423	13,423	18
19	V	23 INSERVICE EDUCATION		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	3,038	3,038	19
20	V	24 TRAVEL SEMINAR		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.			20
21	V	26 INSURANCE		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	2,095	2,095	21
22	V	30 DEPRECIATION		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	3,951	3,951	22
23	V	32 INTEREST		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	479	479	23
24	V	34 RENT		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	2,673	2,673	24
25	V	35 EQUIPMENT RENTAL		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	110	110	25
26	V	5 UTILITIES		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	2,256	2,256	26
27	V	6 MAINTENANCE		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	715	715	27
28	V	43 NONALLOWABLE		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	4,851	4,851	28
29	V	32 MISC INCOME		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	(439)	(439)	29
30	V	3 HOUSEKEEPING		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	395	395	30
31	V	21 OFFICE		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	78,040	78,040	31
32	V	10 NURSING SUPPLIES		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	883	883	32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$ 112,895	\$ * 112,895	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: 07/01/2007 Ending: 06/30/2008

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.			15
16	V	19 PROFESSIONAL FEES		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.			16
17	V	20 DUES, FEES		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	22	22	17
18	V	22 EMPLOYEE BENEFITS		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	6,218	6,218	18
19	V	23 INSERVICE EDUCATION		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	2,174	2,174	19
20	V	24 TRAVEL SEMINAR		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	162	162	20
21	V	26 INSURANCE		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	1,116	1,116	21
22	V	30 DEPRECIATION		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	1,143	1,143	22
23	V	32 INTEREST		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	503	503	23
24	V	34 RENT		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	1,627	1,627	24
25	V	35 EQUIPMENT RENTAL		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	108	108	25
26	V	5 UTILITIES		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	615	615	26
27	V	6 MAINTENANCE		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	498	498	27
28	V	43 NONALLOWABLE		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	2,343	2,343	28
29	V	32 MISC INCOME		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	215	215	29
30	V	3 HOUSEKEEPING		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	274	274	30
31	V	21 OFFICE		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	33,216	33,216	31
32	V	10 NURSING SUPPLIES		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	(1,508)	(1,508)	32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$ 48,726	\$ *	48,726 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:

07/01/2007

Ending:

06/30/2008

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	SECRETARY	BOARD MEMBE	NONE	505	3HRS/MTG	1.00	DIR. FEES	\$ 2,842	L18, C8	1
2	SHAWN JEFFERS	CHAIRMAN	BOARD MEMBE	NONE	463	3HRS/MTG	1.00	DIR. FEES	2,603	L18, C8	2
3	EDWARD CHILDERS	VICE CHAIRMAN	BOARD MEMBE	NONE	505	3HRS/MTG	1.00	DIR. FEES	2,842	L18, C8	3
4	ROBERT BAUER	DIRECTOR	BOARD MEMBE	NONE	272	3HRS/MTG	1.00	DIR. FEES	1,527	L18, C8	4
5	CORA FLOTA	DIRECTOR	BOARD MEMBE	NONE	230	3HRS/MTG	1.00	DIR. FEES	1,294	L18, C8	5
6	ORLAND BAUER	TREASURER	BOARD MEMBE	NONE	484	3HRS/MTG	1.00	DIR. FEES	2,725	L18, C8	6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 13,833		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: 07/01/2007

Ending: 6/30/2008

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	290	18	\$ 8,000	\$	90	\$ 2,483	1
2	19	PROFESSIONAL FEES	290	18	8,801		90	2,731	2
3	20	LICENSE, DUES	290	18	5		90	1	3
4	21	GENERAL OFFICE	290	18	4,178		90	1,297	4
5	23	INSERVICE TRAVEL	290	18	883		90	274	5
6	32	INTEREST	290	18	0		90	0	6
7	32	INTEREST INCOME	290	18	0		90	0	7
8	22	EMPLOYEE BENEFITS	290	18	0		90	0	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				\$ 21,867	\$		\$ 6,786	25

Facility Name & ID Number LAKEVIEW LIVING CENTER

0047811 Report Period Beginning: 07/01/2007

Ending: 6/30/2008

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization PROGRESSIVE HOUSING, INC.
 Street Address 2020 W. WARMEMORIAL DR. SUITE 103
 City / State / Zip Code PEORIA, IL. 61614
 Phone Number (309)685-0595
 Fax Number (309)685-8463

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	18	BOARD FEES	296	19	\$ 3,200	\$	90	\$ 973	1
2	19	PROFESSIONAL FEES	296	19	42,639		90	12,964	2
3	20	LICENSE, DUES	296	19			90		3
4	21	GENERAL OFFICE	296	19	3,630		90	1,104	4
5	23	INSERVICE TRAVEL	296	19	259		90	79	5
6	32	INTEREST	296	19			90		6
7	32	INTEREST INCOME	296	19			90		7
8	22	EMPLOYEE BENEFITS	296	19			90		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				\$ 49,728	\$		\$ 15,120	25

Facility Name & ID Number LAKEVIEW LIVING CENTER

0047811 Report Period Beginning: 07/01/2007

Ending: 6/30/2008

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	NUMBER OF BEDS	302	20	\$ 7,200	\$ 90	\$ 2,145	1
2	19	PROFESSIONAL FEES	NUMBER OF BEDS	302	20	29,894	90	8,909	2
3	20	LICENSE, DUES	NUMBER OF BEDS	302	20	15	90	5	3
4	21	GENERAL OFFICE	NUMBER OF BEDS	302	20	7,047	90	2,100	4
5	23	INSERVICE TRAVEL	NUMBER OF BEDS	302	20	3,147	90	938	5
6	32	INTEREST	NUMBER OF BEDS	302	20		90		6
7	32	INTEREST INCOME	NUMBER OF BEDS	302	20		90		7
8	22	EMPLOYEE BENEFITS	NUMBER OF BEDS	302	20	5,009	90	1,493	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					\$ 52,312	\$	\$ 15,590	25

Facility Name & ID Number LAKEVIEW LIVING CENTER

0047811 Report Period Beginning: 07/01/2007

Ending: 6/30/2008

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.
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 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	NUMBER OF BEDS	308	21	\$ 16,400	\$ 90	\$ 4,792	1
2	19	PROFESSIONAL FEES	NUMBER OF BEDS	308	21	43,975	90	12,850	2
3	20	LICENSE, DUES	NUMBER OF BEDS	308	21		90		3
4	21	GENERAL OFFICE	NUMBER OF BEDS	308	21	13,407	90	3,918	4
5	23	INSERVICE TRAVEL	NUMBER OF BEDS	308	21	2,031	90	593	5
6	32	INTEREST	NUMBER OF BEDS	308	21	1,521	90	444	6
7	32	INTEREST INCOME	NUMBER OF BEDS	308	21		90		7
8	22	EMPLOYEE BENEFITS	NUMBER OF BEDS	308	21	320	90	94	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					\$ 77,654	\$	\$ 22,691	25

Facility Name & ID Number LAKEVIEW LIVING CENTER

0047811 Report Period Beginning: 07/01/2007

Ending: 6/30/2008

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	NUMBER OF BEDS	314	22	\$ 12,000	\$ 90	\$ 3,440	1
2	19	PROFESSIONAL FEES	NUMBER OF BEDS	314	22	13,368	90	3,832	2
3	20	LICENSE, DUES	NUMBER OF BEDS	314	22		90		3
4	21	GENERAL OFFICE	NUMBER OF BEDS	314	22	7,508	90	2,152	4
5	23	INSERVICE TRAVEL	NUMBER OF BEDS	314	22	1,779	90	510	5
6	32	INTEREST	NUMBER OF BEDS	314	22	747	90	214	6
7	32	INTEREST INCOME	NUMBER OF BEDS	314	22	(37,805)	90	(10,836)	7
8	22	EMPLOYEE BENEFITS	NUMBER OF BEDS	314	22	1,680	90	481	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					\$	\$	(207)	25

Facility Name & ID Number LAKEVIEW LIVING CENTER

0047811 Report Period Beginning: 07/01/2007

Ending: 6/30/2008

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	290	18			90		1
2	19	PROFESSIONAL FEES	290	18			90		2
3	20	DUES, FEES	290	18	78		90	24	3
4	22	EMPLOYEE BENEFITS	290	18	16,327		90	5,067	4
5	23	INSERVICE EDUCATION	290	18	7,108		90	2,206	5
6	24	TRAVEL SEMINAR	290	18			90		6
7	26	INSURANCE	290	18	3,549		90	1,102	7
8	30	DEPRECIATION	290	18	6,182		90	1,919	8
9	32	INTEREST	290	18	920		90	285	9
10	34	RENT	290	18	4,468		90	1,387	10
11	35	EQUIPMENT RENTAL	290	18	356		90	110	11
12	5	UTILITIES	290	18	2,613		90	811	12
13	6	MAINTENANCE	290	18	766		90	238	13
14	43	NONALLOWABLE	290	18	2,101		90	652	14
15	32	MISC INCOME	290	18	(50)		90	(15)	15
16	3	HOUSEKEEPING	290	18	760		90	236	16
17	21	OFFICE	290	18	123,352	105,805	90	38,281	17
18	10	NURSING SUPPLIES	290	18	(6,566)		90	(2,038)	18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 161,964	\$ 105,805		\$ 50,265	25

Facility Name & ID Number LAKEVIEW LIVING CENTER

0047811 Report Period Beginning: 07/01/2007

Ending: 6/30/2008

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	NUMBER OF BEDS	296	19	\$	90	\$	1
2	19	PROFESSIONAL FEES	NUMBER OF BEDS	296	19		90		2
3	20	DUES, FEES	NUMBER OF BEDS	296	19	300	90	91	3
4	22	EMPLOYEE BENEFITS	NUMBER OF BEDS	296	19	11,446	90	3,480	4
5	23	INSERVICE EDUCATION	NUMBER OF BEDS	296	19	2,621	90	797	5
6	24	TRAVEL SEMINAR	NUMBER OF BEDS	296	19	1,037	90	315	6
7	26	INSURANCE	NUMBER OF BEDS	296	19	1,765	90	537	7
8	30	DEPRECIATION	NUMBER OF BEDS	296	19	3,192	90	971	8
9	32	INTEREST	NUMBER OF BEDS	296	19	431	90	131	9
10	34	RENT	NUMBER OF BEDS	296	19	2,234	90	679	10
11	35	EQUIPMENT RENTAL	NUMBER OF BEDS	296	19		90		11
12	5	UTILITIES	NUMBER OF BEDS	296	19	1,263	90	384	12
13	6	MAINTENANCE	NUMBER OF BEDS	296	19	718	90	218	13
14	43	NONALLOWABLE	NUMBER OF BEDS	296	19	2,391	90	727	14
15	32	MISC INCOME	NUMBER OF BEDS	296	19		90		15
16	3	HOUSEKEEPING	NUMBER OF BEDS	296	19	360	90	110	16
17	21	OFFICE	NUMBER OF BEDS	296	19	59,287	90	18,026	17
18	10	NURSING SUPPLIES	NUMBER OF BEDS	296	19	81	90	25	18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 87,126	\$ 53,061	\$ 26,491	25

Facility Name & ID Number LAKEVIEW LIVING CENTER

0047811 Report Period Beginning: 07/01/2007

Ending: 6/30/2008

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	NUMBER OF BEDS	302	20	\$	90	\$	1
2	19	PROFESSIONAL FEES	NUMBER OF BEDS	302	20		90		2
3	20	DUES, FEES	NUMBER OF BEDS	302	20	5,285	90	1,575	3
4	22	EMPLOYEE BENEFITS	NUMBER OF BEDS	302	20	34,950	90	10,416	4
5	23	INSERVICE EDUCATION	NUMBER OF BEDS	302	20	9,715	90	2,895	5
6	24	TRAVEL SEMINAR	NUMBER OF BEDS	302	20	2,896	90	863	6
7	26	INSURANCE	NUMBER OF BEDS	302	20	5,377	90	1,602	7
8	30	DEPRECIATION	NUMBER OF BEDS	302	20	9,661	90	2,879	8
9	32	INTEREST	NUMBER OF BEDS	302	20	1,282	90	386	9
10	34	RENT	NUMBER OF BEDS	302	20	7,074	90	2,104	10
11	35	EQUIPMENT RENTAL	NUMBER OF BEDS	302	20	376	90	112	11
12	5	UTILITIES	NUMBER OF BEDS	302	20	3,822	90	1,139	12
13	6	MAINTENANCE	NUMBER OF BEDS	302	20	2,176	90	649	13
14	43	NONALLOWABLE	NUMBER OF BEDS	302	20	16,724	90	4,984	14
15	32	MISC INCOME	NUMBER OF BEDS	302	20		90		15
16	3	HOUSEKEEPING	NUMBER OF BEDS	302	20	1,122	90	334	16
17	21	OFFICE	NUMBER OF BEDS	302	20	189,894	90	56,591	17
18	10	NURSING SUPPLIES	NUMBER OF BEDS	302	20	(719)	90	(214)	18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 289,635	\$ 165,736	\$ 86,315	25

Facility Name & ID Number LAKEVIEW LIVING CENTER

0047811 Report Period Beginning: 07/01/2007

Ending: 6/30/2008

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	NUMBER OF BEDS	308	21	\$	90	\$	1
2	19	PROFESSIONAL FEES	NUMBER OF BEDS	308	21		90		2
3	20	DUES, FEES	NUMBER OF BEDS	308	21	1,456	90	425	3
4	22	EMPLOYEE BENEFITS	NUMBER OF BEDS	308	21	45,935	90	13,423	4
5	23	INSERVICE EDUCATION	NUMBER OF BEDS	308	21	10,397	90	3,038	5
6	24	TRAVEL SEMINAR	NUMBER OF BEDS	308	21		90		6
7	26	INSURANCE	NUMBER OF BEDS	308	21	7,169	90	2,095	7
8	30	DEPRECIATION	NUMBER OF BEDS	308	21	13,522	90	3,951	8
9	32	INTEREST	NUMBER OF BEDS	308	21	1,639	90	479	9
10	34	RENT	NUMBER OF BEDS	308	21	9,148	90	2,673	10
11	35	EQUIPMENT RENTAL	NUMBER OF BEDS	308	21	376	90	110	11
12	5	UTILITIES	NUMBER OF BEDS	308	21	7,720	90	2,256	12
13	6	MAINTENANCE	NUMBER OF BEDS	308	21	2,446	90	715	13
14	43	NONALLOWABLE	NUMBER OF BEDS	308	21	16,600	90	4,851	14
15	32	MISC INCOME	NUMBER OF BEDS	308	21	(1,502)	90	(439)	15
16	3	HOUSEKEEPING	NUMBER OF BEDS	308	21	1,352	90	395	16
17	21	OFFICE	NUMBER OF BEDS	308	21	267,070	236,515	90	78,040
18	10	NURSING SUPPLIES	NUMBER OF BEDS	308	21	3,022	90	883	18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 386,350	\$ 236,515	\$ 112,895	25

Facility Name & ID Number LAKEVIEW LIVING CENTER

0047811 Report Period Beginning: 07/01/2007

Ending: 6/30/2008

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	NUMBER OF BEDS	314	22	\$	90	\$	1
2	19	PROFESSIONAL FEES	NUMBER OF BEDS	314	22		90		2
3	20	DUES, FEES	NUMBER OF BEDS	314	22	76	90	22	3
4	22	EMPLOYEE BENEFITS	NUMBER OF BEDS	314	22	21,693	90	6,218	4
5	23	INSERVICE EDUCATION	NUMBER OF BEDS	314	22	7,585	90	2,174	5
6	24	TRAVEL SEMINAR	NUMBER OF BEDS	314	22	567	90	162	6
7	26	INSURANCE	NUMBER OF BEDS	314	22	3,894	90	1,116	7
8	30	DEPRECIATION	NUMBER OF BEDS	314	22	3,988	90	1,143	8
9	32	INTEREST	NUMBER OF BEDS	314	22	1,756	90	503	9
10	34	RENT	NUMBER OF BEDS	314	22	5,675	90	1,627	10
11	35	EQUIPMENT RENTAL	NUMBER OF BEDS	314	22	376	90	108	11
12	5	UTILITIES	NUMBER OF BEDS	314	22	2,146	90	615	12
13	6	MAINTENANCE	NUMBER OF BEDS	314	22	1,737	90	498	13
14	43	NONALLOWABLE	NUMBER OF BEDS	314	22	8,175	90	2,343	14
15	32	MISC INCOME	NUMBER OF BEDS	314	22	750	90	215	15
16	3	HOUSEKEEPING	NUMBER OF BEDS	314	22	957	90	274	16
17	21	OFFICE	NUMBER OF BEDS	314	22	115,886	90	33,216	17
18	10	NURSING SUPPLIES	NUMBER OF BEDS	314	22	(5,261)	90	(1,508)	18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 170,000	\$ 97,120	\$ 48,726	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	\$ 2,297,719	08/15/26	6.7500	\$ 160,569	1									
2	BANTERRA BANK	X	PURCHASE OF VEHICLES	\$328.14	07/15/04	16,631		06/30/08	6.7500	441	2									
3											3									
4											4									
5											5									
Working Capital																				
6			OFFSET INTERST INCOME/ NONALLOWABLE INT.							(35,965)	6									
7			MISC./PARENT ALLOCATION							6,554	7									
8											8									
9	TOTAL Facility Related			\$328.14		\$ 2,368,370	\$ 2,297,719			\$ 131,599	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	\$ 2,297,719			\$ 131,599	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.)

** 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

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2007 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 2008 report. (Detail and explain your calculation of this accrual on the lines below.)		\$		4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	#VALUE!	7
Real Estate Tax History:				
Real Estate Tax Bill for Calendar Year:	2003	_____	8	
	2004	_____	9	
	2005	_____	10	
	2006	_____	11	
	2007	_____	12	
	FOR BHF USE ONLY			
	13	FROM R. E. TAX STATEMENT FOR 2007	\$	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:** 2007 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 2007 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2007.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2007 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 2008 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.

2007 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 2007 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 2007.

(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 2007 tax bills which were listed in Section A to this statement. Be sure to use the 2007 tax bill which is normally paid during 2008.

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:

07/01/2007 Ending:

06/30/2008

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 36,790 B. General Construction Type: Exterior BRICK Frame WOOD Number of Stories SIX

C. Does the Operating Entity? (a) Own the Facility (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? (a) Own the Equipment (b) Rent equipment from a Related Organization. (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? YES NO
If so, please complete the following:

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

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

XI. OWNERSHIP COSTS:

A. Land.

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

Facility Name & ID Number LAKEVIEW LIVING CENTER

0047811

Report Period Beginning:

07/01/2007

Ending:

06/30/2008

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	\$	\$ 887,294	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	431	15	431		9,135	16
17		BUILDING IMPROVEMENT		1993	112,022	5,290	15	5,290		112,022	17
18		BUILDING IMPROVEMENT		1993	115,471	7,698	15	7,698		111,622	18
19		BUILDING IMPROVEMENT		1994			10				19
20		BUILDING IMPROVEMENT		1995	32,918	2,195	15	2,195		29,205	20
21		INSTALL FIRE HOUSE		1995	1,228	82	15	82		1,031	21
22		ELEVATOR IMPROVEMENTS		1996	3,356	224	15	224		2,761	22
23		RECEPTION AREA		1996	1,598	107	15	107		1,305	23
24		TWO SETS OF STEEL DOORS		1995	3,250	217	15	217		2,745	24
25		CABINETS IN RECEPTION AREA		1995	3,500	233	15	233		2,935	25
26		MOTOR FOR ELEVATOR		1996	2,042	136	15	136		1,622	26
27		TUB RESURFACING		1996	4,900	327	15	327		3,866	27
28		CONCRETE RAMP		1996	700	46	15	46		548	28
29		ROOF SHAFT & EXHAUST		1996	1,110	74	15	74		870	29
30		FLOOR DRAIN		1997	2,300	153	15	153		1,737	30
31		BOX ELEVATOR		1997	1,950	130	15	130		1,452	31
32		CONCRETE LUNCH AREA		1997	4,313	286	15	286		3,209	32
33		ROOF WORK		1997	45,658	3,044	15	3,044		33,990	33
34		BOX ON ELEVATOR		1998	525	35	15	35		382	34
35		LIGHTING		1998	2,715	181	15	181		1,946	35
36		PLUMBING		1998	700	47	15	47		490	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:

07/01/2007

Ending:

06/30/2008

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	\$	\$ 1,823	37
38	ROOF TOP EXHAUST FAN	1998	635	42	15	42		448	38
39	ELECTRIC DOOR STRIKE	1998	582	39	15	39		424	39
40	GLASS	1998	679	45	15	45		490	40
41	CARPET	1999	518	35	15	35		326	41
42	DOOR	1999	680	45	15	45		393	42
43	BATHROOM RENOVATIONS	2000	8,800	587	15	587		4,437	43
44	PLUMBING	2001	2,100	140	15	140		1,003	44
45	SHOWER BASE AND TILES	2001	2,200	147	15	147		1,027	45
46	TUCK POINTING BRICK	2001	43,284	2,886	15	2,886		19,478	46
47	STEEL DOORS	2002	1,430	95	15	95		611	47
48	RESURFACE BATHTUB	2002	1,120	75	15	75		473	48
49	WATER LINE MOTOR	2002	1,275	85	15	85		531	49
50	ELEVATOR EDGE	2001	1,696	113	15	113		782	50
51	ELEVATOR DOORS	2002	920	61	15	61		393	51
52	WATER LINE	2002	1,750	117	15	117		710	52
53	HOPKINS ELEVATOR REPAIR	2004	1,009	67	15	67		314	53
54	DURAGLAZE TUB REFURNISHING	2004	2,845	190	15	190		791	54
55	ROOF REPAIRS	2004	1,050	70	15	70		280	55
56	FLOORING	2004	2,928	195	15	195		780	56
57	WINDOWS	2004	1,885	126	15	126		472	57
58	ELEVATOR REPAIRS	2004	1,480	99	15	99		371	58
59	ELEVATOR DRIVE UNIT	2005	4,273	285	15	285		807	59
60	EXTERINAL CABLE SETUP	2005	1,264	84	15	84		238	60
61	NEW WINDOWS	2005	560	37	15	37		105	61
62	TUB RESURFACING	2005	3,505	234	15	234		604	62
63	NEW ELEVATOR GENERATOR	2006	5,324	355	15	355		739	63
64	ELEVATOR KEY LOCK	2006	2,326	155	15	155		310	64
65	WATER CIRCULATION REPAIR	2006	680	45	15	45		90	65
66	REPLACE ELEVATOR MOTOR	2006	4,569	305	15	305		508	66
67	SITE GAURDS ELEVATOR	2006	1,489	99	15	99		153	67
68	CIRCULATING PUMP	2007	1,030	69	15	69		103	68
69	WATERLINE SECTIONS	2007	1,200	53	15	53		53	69
70	TOTAL (lines 4 thru 69)		\$ 2,341,785	\$ 73,399		\$ 73,399	\$	\$ 1,549,027	70

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

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	
1	Totals from Page 12A, Carried Forward		\$ 2,341,785	\$ 73,399		\$ 73,399	\$	\$ 1,549,027	1
2	REPLACE BOILER LINE	2008	1,800	30	15	30		30	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	TOTAL (lines 1 thru 33)		\$ 2,343,585	\$ 73,429		\$ 73,429	\$	\$ 1,549,057	34

**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	\$ 454,117	\$ 48,431	\$ 48,431	\$	5-10 YRS	\$ 270,585	71
72	Current Year Purchases	30,657	741	741		5-10 YRS	741	72
73	Fully Depreciated Assets	685,969	997	997		5-10 YRS	685,969	73
74	ALLOCATED FROM PARENT		10,863	10,863				74
75	TOTALS	\$ 1,170,743	\$ 61,032	\$ 61,032	\$		\$ 957,295	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	\$	\$	\$	5	\$ 23,986	76
77	RESIDENT TRANSPORTA	2003 FORD VAN	2003	24,501	4,492	4,492		5	24,501	77
78	RESIDENT TRANSPORTA	2004 CHEVY VENTURE	2004	18,511	3,702	3,702		5	14,809	78
79										79
80	TOTALS			\$ 66,998	\$ 8,194	\$ 8,194	\$		\$ 63,296	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)		\$ 3,622,842	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)		\$ 142,655	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)		\$ 142,655	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)		\$ 2,569,648	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: 07/01/2007

Ending: 06/30/2008

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	SCH 6E-I				8,474			5
6					_____			6
7	TOTAL				\$ 8,474			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.	_____ /2009	\$ _____
13.	_____ /2010	\$ _____
14.	_____ /2011	\$ _____

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: \$ 3,403 Description: DISH WASHER, POSTAGE AND SCH 6-E-I

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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

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

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

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

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. <u>CLASSROOM PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
--	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

	Service	1 Schedule V Line & Column Reference	2 Staff		4 Outside Practitioner (other than consultant)		6 Supplies (Actual or Allocated)	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	5 Units Cost					
					Units	Cost				
1	Licensed Occupational Therapist		hrs	\$		\$	\$		\$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									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: 07/01/2007

Ending:

06/30/2008

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 06/30/2008

(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	23,028		2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance (72,031))	1,026,886		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	472		6
7	Other Prepaid Expenses	1,773		7
8	Accounts Receivable (owners or related parties)	4,786,023		8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 5,839,682	\$	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	757,601		15
16	Equipment, at Historical Cost	1,237,741		16
17	Accumulated Depreciation (book methods)	(2,569,648)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	378,429		21
22	Other Long-Term Assets (specify):			22
23	Other(specify): LOAN COST	56,815		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,488,438	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 7,328,120	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 195,376	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	23,028		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	113,688		30
31	Accrued Taxes Payable (excluding real estate taxes)	888		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	57,948		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)	\$ 390,928	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	16,633		39
40	Mortgage Payable	2,297,719		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)	\$ 2,314,352	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 2,705,280	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 4,622,840	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 7,328,120	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 4,650,823	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 4,650,823	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(27,983)	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)	\$ (27,983)	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)	\$ 4,622,840	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number LAKEVIEW LIVING CENTER

0047811

Report Period Beginning: 07/01/2007

Ending: 06/30/2008

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	\$ 3,771,295	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,771,295	3
B. Ancillary Revenue			
4	Day Care	917,283	4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 917,283	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	682	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)	\$ 682	23
D. Non-Operating Revenue			
24	Contributions	377	24
25	Interest and Other Investment Income***	31,310	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 31,687	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)	\$ 4,720,947	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	705,995	31
32	Health Care	1,871,002	32
33	General Administration	680,610	33
B. Capital Expense			
34	Ownership	300,000	34
C. Ancillary Expense			
35	Special Cost Centers	932,963	35
36	Provider Participation Fee	258,360	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 4,748,930	40
41	Income before Income Taxes (line 30 minus line 40)**	(27,983)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (27,983)	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: 07/01/2007

Ending:

06/30/2008

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	1,831	2,011	\$ 51,291	\$ 25.51	1
2	Assistant Director of Nursing	2,253	2,487	48,342	19.44	2
3	Registered Nurses					3
4	Licensed Practical Nurses	10,445	11,470	221,116	19.28	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	1,821	2,132	22,056	10.35	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	14,606	16,477	182,755	11.09	15
16	Dishwashers					16
17	Maintenance Workers	2,969	3,187	47,627	14.94	17
18	Housekeepers	7,308	8,355	84,655	10.13	18
19	Laundry	4,251	4,766	56,499	11.85	19
20	Administrator	2,423	2,685	72,668	27.06	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	9,092	9,815	113,010	11.51	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)	7,398	7,983	120,847	15.14	28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)	93,102	103,177	1,099,894	10.66	30
31	Medical Records	3,487	3,709	29,091	7.84	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	160,986	178,254	\$ 2,149,851 *	\$ 12.06	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	181	\$ 9,630	L1, C3	35
36	Medical Director				36
37	Medical Records Consultant				37
38	Nurse Consultant			L10, C3	38
39	Pharmacist Consultant	MONTHLY	1,792	L10, C3	39
40	Physical Therapy Consultant	76	4,734	L10A, C3	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	205	10,250	L10A, C3	43
44	Activity Consultant				44
45	Social Service Consultant	291	17,325	L12, C3	45
46	Other(specify) <u>PSYCHOLOGICAL</u>	MONTHLY	48,720	L10, C3	46
47					47
48					48
49	TOTAL (lines 35 - 48)	753	\$ 92,451		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	3,087	119,739	L10, C3	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	3,087	\$ 119,739		53

