FOR BHF USE

LL1

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

2011
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2011)

I. IDPH License ID Number: 0046169

Facility Name: Lakewood Nursing & Rehab Center, Llc

Address: 1112 North Eastern Avenue (Number) Plainfield (City) 60544 (Zip Code)

County: Will

Telephone Number: (815) 436-3400 **Fax #** (815) 436-1357

HFS ID Number:

Date of Initial License for Current Owners: 02/01/03

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
		X	Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Steve Lavenda **Telephone Number:** (847) 236-1111
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/11 to 12/31/11 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

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

Officer or Administrator of Provider
(Signed)
(Date)
(Type or Print Name)
(Title)

Paid Preparer
(Signed)
(Date)
(Print Name and Title) Lisa M. Hanlon, C.P.A.
(Firm Name & Address) Frost, Ruttenberg & Rothblatt, P.C.
111 Pfingsten Road, Suite 300 Deerfield, IL 60015
(Telephone) (847) 236-1111 Fax # (847) 236-1155

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lakewood Nursing & Rehab Center, Llc # 0046169 Report Period Beginning: 01/01/11 Ending: 12/31/11

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 N/A

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	131	Skilled (SNF)	131	47,815	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	131	TOTALS	131	47,815	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	26,015	5,919	10,422	42,356	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	26,015	5,919	10,422	42,356	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 88.58%

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

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 02/01/2003

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 02/01/2003 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 131 and days of care provided 9,971

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/2011 Fiscal Year: 12/31/2011

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lakewood Nursing & Rehab Center, Llc # 0046169 Report Period Beginning: 01/01/11 Ending: 12/31/11

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	291,745	51,492	9,138	352,375		352,375	6,072	358,447			1
2	Food Purchase		254,491		254,491		254,491	(1,431)	253,060			2
3	Housekeeping	194,249	49,841		244,090		244,090	(2,327)	241,763			3
4	Laundry	51,383	18,875		70,258		70,258	(814)	69,444			4
5	Heat and Other Utilities			180,056	180,056		180,056	925	180,981			5
6	Maintenance	113,812		220,445	334,257		334,257	5,510	339,767			6
7	Other (specify):*							2,119	2,119			7
8	TOTAL General Services	651,189	374,699	409,639	1,435,527		1,435,527	10,054	1,445,581			8
	B. Health Care and Programs											
9	Medical Director			24,500	24,500		24,500		24,500			9
10	Nursing and Medical Records	2,812,196	198,065	72,633	3,082,894		3,082,894	25,441	3,108,335			10
10a	Therapy	240,571		148	240,719		240,719		240,719			10a
11	Activities	142,066	30,308		172,374		172,374		172,374			11
12	Social Services	197,037		8,286	205,323		205,323	5,102	210,425			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*							8,688	8,688			15
16	TOTAL Health Care and Programs	3,391,870	228,373	105,567	3,725,810		3,725,810	39,231	3,765,041			16
	C. General Administration											
17	Administrative	152,526			152,526		152,526	40,356	192,882			17
18	Directors Fees											18
19	Professional Services			537,169	537,169		537,169	(410,695)	126,474			19
20	Dues, Fees, Subscriptions & Promotions			29,636	29,636		29,636	(15,644)	13,992			20
21	Clerical & General Office Expenses	159,751	27,363	212,505	399,619		399,619	(50,087)	349,532			21
22	Employee Benefits & Payroll Taxes			727,376	727,376		727,376	(13,229)	714,147			22
23	Inservice Training & Education											23
24	Travel and Seminar			3,880	3,880		3,880	1,697	5,577			24
25	Other Admin. Staff Transportation			11,019	11,019		11,019	370	11,389			25
26	Insurance-Prop.Liab.Malpractice			137,233	137,233		137,233	823	138,056			26
27	Other (specify):*							23,364	23,364			27
28	TOTAL General Administration	312,277	27,363	1,658,818	1,998,458		1,998,458	(423,045)	1,575,413			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,355,336	630,435	2,174,024	7,159,795		7,159,795	(373,759)	6,786,036			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 Nursing & Rehab Center, Llc #0046169 Report Period Beginning: 01/01/11 Ending: 12/31/11

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			80,983	80,983		80,983	383,343	464,326			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			112	112		112	330,998	331,110			32
33	Real Estate Taxes			110,695	110,695		110,695	1,369	112,064			33
34	Rent-Facility & Grounds			526,797	526,797		526,797	(525,965)	832			34
35	Rent-Equipment & Vehicles			5,949	5,949		5,949	(1,570)	4,379			35
36	Other (specify):*											36
37	**TOTAL Ownership**			724,536	724,536		724,536	188,176	912,712			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		907,190	950,868	1,858,058		1,858,058	(73,640)	1,784,418			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			221,597	221,597		221,597		221,597			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		907,190	1,172,465	2,079,655		2,079,655	(73,640)	2,006,015			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	4,355,336	1,537,625	4,071,025	9,963,986		9,963,986	(259,223)	9,704,763			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 Nursing & Rehab Center, Llc # 0046169 Report Period Beginning: 01/01/11 Ending: 12/31/11

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.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(1,292)	02		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	151,209	30		9
10	Interest and Other Investment Income	(15,855)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(351)	02		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				18
19	Entertainment				19
20	Contributions	(750)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(141,431)	21		24
25	Fund Raising, Advertising and Promotional	(17,653)	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	(133,907)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (160,030)		$	30

BHF USE ONLY								
48		49		50		51		52	

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

		1 Amount	2 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)	(99,194)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (99,194)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (259,223)		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 Yes	2 No	3 Amount	4 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

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Lakewood Nursing & Rehab Center, Llc

ID# 0046169

Report Period Beginning: 01/01/11

Ending: 12/31/11

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Patient Clothing	$ (1,507)	10	1
2	Collection Expense	(5,942)	21	2
3	Legal Expenses	(14,551)	19	3
4	Related Party Interest Expense	(59,136)	32	4
5	Other Income	(544)	21	5
6	Building Co. Legal Expenses	(10,390)	19	6
7	Building Co. Filing Fees	(250)	21	7
8	Building Co. Amortization Expense	(10,282)	31	8
9	Capitalized R&M	(2,710)	06	9
10	Building Co. Loan Expense	(28,595)	21	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**	(133,907)		49

Lakewood Nursing & Rehab Center, Llc

ID# 0046169

Report Period Beginning: 01/01/11

Ending: 12/31/11

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
50		$		1
51				2
52				3
53				4
54				5
55				6
56				7
57				8
58				9
59				10
60				11
61				12
62				13
63				14
64				15
65				16
66				17
67				18
68				19
69				20
70				21
71				22
72				23
73				24
74				25
75				26
76				27
77				28
78				29
79				30
80				31
81				32
82				33
83				34
84				35
85				36
86				37
87				38
88				39
89				40
90				41
91				42
92				43
93				44
94				45
95				46
96				47
97				48
98				49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Lakewood Nursing & Rehab Center, Llc **#** 0046169 **Report Period Beginning:** 01/01/11 **Ending:** 12/31/11

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			221		6,169		(318)					6,072	1
2	Food Purchase	(1,643)		212									(1,431)	2
3	Housekeeping			447		80			(2,854)				(2,327)	3
4	Laundry								(814)				(814)	4
5	Heat and Other Utilities			784		141							925	5
6	Maintenance	(2,710)		2,252	5,959	29			(20)				5,510	6
7	Other (specify):*				1,081	1,038							2,119	7
8	**TOTAL General Services**	(4,353)		3,916	7,040	7,457		(318)	(3,687)				10,054	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(1,507)				34,424		(560)	(6,915)				25,441	10
10a	Therapy													10a
11	Activities													11
12	Social Services					5,102							5,102	12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*					6,653	2,035						8,688	15
16	**TOTAL Health Care and Programs**	(1,507)				46,179	2,035	(560)	(6,915)				39,231	16
	C. General Administration													
17	Administrative			2,352	8,009	29,995							40,356	17
18	Directors Fees													18
19	Professional Services	(24,941)	10,390	(307,615)		(88,529)							(410,695)	19
20	Fees, Subscriptions & Promotions	(18,403)		2,633		126							(15,644)	20
21	Clerical & General Office Expenses	(176,762)	28,845	9,754	81,871	6,205							(50,087)	21
22	Employee Benefits & Payroll Taxes				(11,020)		(2,035)		(174)				(13,229)	22
23	Inservice Training & Education													23
24	Travel and Seminar			146		1,551							1,697	24
25	Other Admin. Staff Transportation			370									370	25
26	Insurance-Prop.Liab.Malpractice			701		122							823	26
27	Other (specify):*				17,655	5,709							23,364	27
28	**TOTAL General Administration**	(220,106)	39,235	(291,659)	96,515	(44,821)	(2,035)		(174)				(423,045)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(225,966)	39,235	(287,743)	103,555	8,815		(879)	(10,776)				(373,759)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Lakewood Nursing & Rehab Center, Llc # 0046169 **Report Period Beginning:** 01/01/11 **Ending:** 12/31/11

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

	Capital Expense D. Ownership	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)	
30	Depreciation	151,209	223,402	7,572		1,160							383,343	30
31	Amortization of Pre-Op. & Org.	(10,282)	10,282											31
32	Interest	(74,991)	399,181	6,440		368							330,998	32
33	Real Estate Taxes			1,161		208							1,369	33
34	Rent-Facility & Grounds		(525,965)										(525,965)	34
35	Rent-Equipment & Vehicles			2,870						(4,440)			(1,570)	35
36	Other (specify):*													36
37	**TOTAL Ownership**	65,936	106,900	18,043		1,736				(4,440)			188,176	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers							(4,577)	(8,543)	(18,598)	(41,876)	(46)	(73,640)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*													43
44	**TOTAL Special Cost Centers**							(4,577)	(8,543)	(18,598)	(41,876)	(46)	(73,640)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(160,030)	146,135	(269,700)	103,555	10,551		(5,456)	(19,319)	(23,037)	(41,876)	(46)	(259,223)	45

Facility Name & ID Number Lakewood Nursing & Rehab Center, Llc # 0046169 Report Period Beginning: 01/01/11 Ending: 12/31/11

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See 6-Supplemental		See 6-Supplemental		See 6-Supplmental		

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. [X] 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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rental Income	$ 525,965	Lakewood Plainfield Property LLC	100.00%	$	$ (525,965)	1
2	V	33	Rent - RE Taxes	110,695	Lakewood Plainfield Property LLC	100.00%		(110,695)	2
3	V	19	Legal Expenses		Lakewood Plainfield Property LLC	100.00%	10,390	10,390	3
4	V	21	Misc. Adm Exp - Filing Fees		Lakewood Plainfield Property LLC	100.00%	250	250	4
5	V	30	Depreciation		Lakewood Plainfield Property LLC	100.00%	223,402	223,402	5
6	V	31	Amortization		Lakewood Plainfield Property LLC	100.00%	10,282	10,282	6
7	V	33	Rental Estate Tax Expense		Lakewood Plainfield Property LLC	100.00%	110,695	110,695	7
8	V	32	Interest - Business Partners		Lakewood Plainfield Property LLC	100.00%	183,575	183,575	8
9	V	32	Interest - Hunter Management		Lakewood Plainfield Property LLC	100.00%	37,596	37,596	9
10	V	32	Interest-Rothner Health Venture GII		Lakewood Plainfield Property LLC	100.00%	21,540	21,540	10
11	V	32	Interest-Citizens FNB		Lakewood Plainfield Property LLC	100.00%	156,470	156,470	11
12	V	21	Current Loan Expense		Lakewood Plainfield Property LLC	100.00%	28,595	28,595	12
13	V								13
14	Total			$ 636,660			$ 782,795	$ * 146,135	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lakewood Nursing & Rehab Center, Llc # 0046169 Report Period Beginning: 01/01/11 Ending: 12/31/11

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. [X] 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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	01	Dietary	$	Extended Care Consulting, LLC	100.00%	$ 221	$ 221	15
16	V	02	Food		Extended Care Consulting, LLC	100.00%	212	212	16
17	V	03	Housekeeping		Extended Care Consulting, LLC	100.00%	447	447	17
18	V	05	Utilities		Extended Care Consulting, LLC	100.00%	784	784	18
19	V	06	Maintenance		Extended Care Consulting, LLC	100.00%	2,252	2,252	19
20	V	17	Administrative		Extended Care Consulting, LLC	100.00%	2,352	2,352	20
21	V	19	Professional Fees	313,670	Extended Care Consulting, LLC	100.00%	4,397	(307,615)	21
22	V	20	Dues and Subscriptions		Extended Care Consulting, LLC	100.00%	2,633	2,633	22
23	V	21	Office and Clerical		Extended Care Consulting, LLC	100.00%	9,754	9,754	23
24	V	24	Seminar and Travel		Extended Care Consulting, LLC	100.00%	146	146	24
25	V	25	Other Staff Admin. Trans.		Extended Care Consulting, LLC	100.00%	370	370	25
26	V	26	Insurance		Extended Care Consulting, LLC	100.00%	701	701	26
27	V	30	Depreciation		Extended Care Consulting, LLC	100.00%	7,572	7,572	27
28	V	32	Interest		Extended Care Consulting, LLC	100.00%	6,440	6,440	28
29	V	33	Real Estate Taxes		Extended Care Consulting, LLC	100.00%	1,161	1,161	29
30	V	34	Rent - Building		Extended Care Consulting, LLC	100.00%			30
31	V	35	Rent - Equipment & Auto		Extended Care Consulting, LLC	100.00%	2,870	2,870	31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 313,670			$ 42,312	$ * (269,700)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lakewood Nursing & Rehab Center, Llc # 0046169 Report Period Beginning: 01/01/11 Ending: 12/31/11

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. [X] 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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	06	Maintenance (Pooled)		Extended Care Consulting, LLC	100.00%	5,959	$ 5,959	15
16	V	06	Maintenance (Direct)	83	Extended Care Consulting, LLC	100.00%	83		16
17	V	07	Emp. Ben. - Gen. Serv. (Pooled)		Extended Care Consulting, LLC	100.00%	1,069	1,069	17
18	V	07	Emp. Ben. - Gen. Serv. (Direct)		Extended Care Consulting, LLC	100.00%	12	12	18
19	V	12	Admission (Direct)		Extended Care Consulting, LLC	100.00%			19
20	V	15	Emp. Ben. - Nursing (Direct)		Extended Care Consulting, LLC	100.00%			20
21	V	17	Administrative (Pooled)		Extended Care Consulting, LLC	100.00%	8,009	8,009	21
22	V	21	Office and Clerical (Pooled)		Extended Care Consulting, LLC	100.00%	81,871	81,871	22
23	V	21	Office and Clerical (Direct)	21,849	Extended Care Consulting, LLC	100.00%	21,849		23
24	V	27	Emp. Ben. - Gen. Admin. (Pooled)		Extended Care Consulting, LLC	100.00%	15,465	15,465	24
25	V	27	Emp. Ben. - Gen. Admin. (Direct)		Extended Care Consulting, LLC	100.00%	2,190	2,190	25
26	V	22	Employee Benefits	11,020	Extended Care Consulting, LLC	100.00%		(11,020)	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			$ 32,952			$ 136,507	$ * 103,555	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lakewood Nursing & Rehab Center, Llc # 0046169 Report Period Beginning: 01/01/11 Ending: 12/31/11

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. [X] 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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	03	Housekeeping	$	Extended Care Clinical, LLC	100.00%	$ 80	$ 80	15
16	V	05	Utilities		Extended Care Clinical, LLC	100.00%	141	141	16
17	V	06	Maintenance		Extended Care Clinical, LLC	100.00%	29	29	17
18	V	19	Professional Fees	104,004	Extended Care Clinical, LLC	100.00%	15,475	(88,529)	18
19	V	20	Dues and Subscriptions		Extended Care Clinical, LLC	100.00%	126	126	19
20	V	21	Office & Clerical		Extended Care Clinical, LLC	100.00%	2,287	2,287	20
21	V	24	Travel and Seminar		Extended Care Clinical, LLC	100.00%	1,551	1,551	21
22	V	26	Insurance		Extended Care Clinical, LLC	100.00%	122	122	22
23	V	30	Depreciation		Extended Care Clinical, LLC	100.00%	1,160	1,160	23
24	V	32	Interest		Extended Care Clinical, LLC	100.00%	368	368	24
25	V	33	Real Estate Taxes		Extended Care Clinical, LLC	100.00%	208	208	25
26	V	01	Dietary Salary		Extended Care Clinical, LLC	100.00%	6,169	6,169	26
27	V	07	Emp. Ben. - Gen. Serv.		Extended Care Clinical, LLC	100.00%	1,038	1,038	27
28	V	10	Nursing Salary		Extended Care Clinical, LLC	100.00%	34,424	34,424	28
29	V	10a	Rehab Salary		Extended Care Clinical, LLC	100.00%			29
30	V	12	Social Service Salary		Extended Care Clinical, LLC	100.00%	5,102	5,102	30
31	V	15	Emp. Ben. - Healthcare		Extended Care Clinical, LLC	100.00%	6,653	6,653	31
32	V	17	Administration Salary		Extended Care Clinical, LLC	100.00%	29,995	29,995	32
33	V	21	Office Salary		Extended Care Clinical, LLC	100.00%	3,918	3,918	33
34	V	27	Emp. Ben. - Gen. Admin.		Extended Care Clinical, LLC	100.00%	5,709	5,709	34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 104,004			$ 114,555	$ * 10,551	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lakewood Nursing & Rehab Center, Llc # 0046169 Report Period Beginning: 01/01/11 Ending: 12/31/11

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. [X] 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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	01	Dietary Salary	$	Extended Care Clinical, LLC	100.00%	$	$	15
16	V	07	Emp. Ben. - General		Extended Care Clinical, LLC	100.00%			16
17	V	10	Nursing / Medical Record Salary	13,547	Extended Care Clinical, LLC	100.00%	13,547		17
18	V	12	Social Service / Admission Salary	8,035	Extended Care Clinical, LLC	100.00%	8,035		18
19	V	15	Emp. Ben. - Healthcare		Extended Care Clinical, LLC	100.00%	2,035	2,035	19
20	V	17	Administration Salary		Extended Care Clinical, LLC	100.00%			20
21	V	27	Emp. Ben. - Gen. Admin.		Extended Care Clinical, LLC	100.00%			21
22	V	22	Employee Benefits	2,035	Extended Care Clinical, LLC	100.00%		(2,035)	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			$ 23,617			$ 23,617	$ *	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lakewood Nursing & Rehab Center, Llc # 0046169 Report Period Beginning: 01/01/11 Ending: 12/31/11

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. [X] 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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	1	Dietary Supplies, Supplements	$ 664	Care Centers Health Systems, Inc.	100.00%	$ 346	$ (318)	15
16	V	2	Food		Care Centers Health Systems, Inc.	100.00%			16
17	V	10	Nursing Supplies	1,169	Care Centers Health Systems, Inc.	100.00%	609	(560)	17
18	V	39	Ancillary Expense	9,551	Care Centers Health Systems, Inc.	100.00%	4,974	(4,577)	18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 11,385			$ 5,929	$ * (5,456)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lakewood Nursing & Rehab Center, Llc # 0046169 Report Period Beginning: 01/01/11 Ending: 12/31/11

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. [X] 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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	1	Dietary	$	Xcel Supply, LLC	100.00%	$	$	15
16	V	3	Housekeeping	47,074	Xcel Supply, LLC	100.00%	44,220	(2,854)	16
17	V	4	Laundry	13,428	Xcel Supply, LLC	100.00%	12,614	(814)	17
18	V	6	Repairs & Maintenance	322	Xcel Supply, LLC	100.00%	302	(20)	18
19	V	10	Nursing	114,073	Xcel Supply, LLC	100.00%	107,157	(6,915)	19
20	V	11	Activities		Xcel Supply, LLC	100.00%			20
21	V	21	Office And Clerical		Xcel Supply, LLC	100.00%			21
22	V	22	Employee Benefits	2,864	Xcel Supply, LLC	100.00%	2,690	(174)	22
23	V	30	Fixed Assets-Depreciation		Xcel Supply, LLC	100.00%			23
24	V	39	Ancillary	140,917	Xcel Supply, LLC	100.00%	132,374	(8,543)	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			$ 318,678			$ 299,358	$ * (19,319)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lakewood Nursing & Rehab Center, Llc # 0046169 Report Period Beginning: 01/01/11 Ending: 12/31/11

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. [X] 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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	39	Ventilator Equipment	28,210	Vent Lease LLC	100.00%	9,612	(18,598)	15
16	V	39	Other Ancillary		Vent Lease LLC	100.00%			16
17	V	35	Matrix Leasing	4,440	Vent Lease LLC	100.00%		(4,440)	17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V	22	Employee Health Insurance	$	CCS Employee Benefits Group	100.00%	$ 136,067	136,067	27
28	V								28
29	V								29
30	V								30
31	V	22	Employee Health Insurance	136,067	CCS Employee Benefits Group	100.00%		(136,067)	31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 168,717			$ 145,679	$ * (23,037)	39

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

Facility Name & ID Number Lakewood Nursing & Rehab Center, Llc # 0046169 Report Period Beginning: 01/01/11 Ending: 12/31/11

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. [X] 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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	39	Therapy	$ 879,792	TriCare Rehab	100.00%	$ 837,916	$ (41,876)	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 879,792			$ 837,916	$ * (41,876)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lakewood Nursing & Rehab Center, Llc # 0046169 Report Period Beginning: 01/01/11 Ending: 12/31/11

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. [X] 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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	6	R&M - Equipment	$	Reliable Medical of the Midwest, LLC	100.00%	$	$	15
16	V	10	Nursing Supplies		Reliable Medical of the Midwest, LLC	100.00%			16
17	V	39	Ancillary Expense	5,110	Reliable Medical of the Midwest, LLC	100.00%	5,064	(46)	17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 5,110			$ 5,064	$ * (46)	39

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

Facility Name & ID Number Lakewood Nursing & Rehab Center, Llc # 0046169 Report Period Beginning: 01/01/11 Ending: 12/31/11

VII. RELATED PARTIES

A. (Continued) Enter below the names of ALL owners and related organizations (parties) as defined in the instructions.

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	ERIC ROTHNER	1.000%	WHEATON CARE CENTER	WHEATON	LAKEWOOD PLAINFIELD PROI		BUILDING CO.	1
2	ROTHNER HEALTH VENTURES G II, LLC	99.000%	AVENUE CARE NURSING AND REHABILITATION CENTER,LLC	CHICAGO	EXTENDED CARE CONSULTING	EVANSTON	MANAGEMENT/BOOKKI	2
3			BEECHER MANOR NURSING AND REHABILITATION CENTER, LLC	BEECHER	EXTENDED CARE CLINICAL	EVANSTON	ADMINISTRATIVE	3
4			BOULEVARD CARE NURSING AND REHABILITATION CENTER,LLC	CHICAGO	CARE CENTER HEALTH SYSTE	DES PLAINES	DIETARY & FOOD SUPPI	4
5			BRIAR PLACE, LTD.	INDIAN HEAD	CCS EMPLOYEE BENEFITS GR	EVANSTON	HEALTH INSURANCE	5
6			CHATEAU NURSING AND REHABILITATION CENTER, L.L.C.	WILLOWBROOK	XCEL MEDICAL SUPPLY	EVANSTON	MEDICAL SUPPLIES	6
7			COUNTRYSIDE NURSING AND REHABILITATION CENTER, LLC	DOLTON	VENTLEASE, LLLC	EVANSTON	VENTILATOR RENTAL	7
8			DYER NURSING & REHAB	DYER, IN	TRICARE REHAB	HILLSIDE	THERAPY	8
9			GRASMERE PLACE, LLC	CHICAGO	RELIABLE MEDICAL SUPPLY C	DES PLAINES	MEDICAL SUPPLY	9
10			HILLCREST NURSING AND REHABILITATION CENTER,LLC	JOLIET	2201 MAIN, LLC	EVANSTON	BLDG COMPANY	10
11			HOMESTEAD NURSING & REAHB	LINCOLN, NE				11
12			TRI-STATE NURSING & REHABILITATION CENTER, INC.	LANSING				12
13			LAKE COUNTY NURSING & REHAB	EAST CHICAGO, IN				13
14			LANCASTER MANOR	LINCOLN, NE				14
15			LEMONT NURSING AND REHABILITATION CENTER, L.L.C.	LEMONT				15
16			MCKINLEY HEALTH CARE CENTER	CANTON, OH				16
17			OAK PARK HEALTHCARE CENTER, L.L.C.	OAK PARK				17
18			PARK HOUSE NURSING AND REHABILITATION CENTER,LLC	CHICAGO				18
19			PRAIRIE MANOR NURSING & REHABILITATION CENTER, L.L.C.	CHICAGO HEIGHTS				19
20			PRAIRIE VILLAGE HEALTHCARE CENTER, INC.	JACKSONVILLE				20
21			RAINBOW BEACH QOC, L.L.C.	CHICAGO				21
22			SEBOS NURSING & REHAB	HOLBART, IN				22
23			GOLDEN PLAINES	HUTCHINSON, KS				23
24			SHERIDAN SHORES CARE & REHABILITATION CENTER, INC.	CHICAGO				24
25			SNOW VALLEY NURSING AND REHABILITATION CENTER, L.L.C.	LISLE				25
26			SOUTH SUBURBAN REHABILITATION CENTER, LLC	HOMEWOOD				26
27			TIMBER POINT HEALTHCARE CENTER, INC.	CAMP POINT				27
28								28
29								29
30								30

Facility Name & ID Number Lakewood Nursing & Rehab Center, Llc # 0046169 Report Period Beginning: 01/01/11 Ending: 12/31/11

VII. RELATED PARTIES

A. (Continued) **Enter below the names of ALL owners and related organizations (parties) as defined in the instructions.**

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
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

Facility Name & ID Number Lakewood Nursing & Rehab Center, Llc # 0046169 Report Period Beginning: 01/01/11 Ending: 12/31/11

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	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	G. Matt Silvers	Relative	Administrative	0.00%	See Attached	1.01	2.53%	Alloc. Salary	$ 3,996	17-7	1
2	Mark Steinberg	Relative	Administrative	0.00%	See Attached	2.79	3.18%	Al Sal/Al Fee	9,131	17-7	2
3	Adam Vales	Relative	Clerical	0.00%	See Attached	1	2.50%	Alloc. Salary	1,775	22-7	3
4											4
5											5
6											6
7											7
8											8
9	Where applicable, the amounts reported on this page have been adjusted from the actual costs to reflect only the amounts										9
10	anticipated to be considered allowable by the IL. Dept. of HFS.										10
11											11
12											12
13								TOTAL	$ 14,902		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 Lakewood Nursing & Rehab Center, Llc # 0046169 Report Period Beginning: 01/01/11 Ending: 12/31/11

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 [X]

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

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	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

Facility Name & ID Number Lakewood Nursing & Rehab Center, Llc # 0046169 Report Period Beginning: 01/01/11 Ending: 12/31/11

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 [X] NO [ ]

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

Name of Related Organization: Extended Care Consulting, LLC
Street Address: 2201 West Main Street
City / State / Zip Code: Evanston, Illinois 60202
Phone Number: (847) 905-3000
Fax Number: (847) 905-3030

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	01	Dietary	Patient Days	1,332,501	31	$ 6,942	$	42,356	$ 221	1
2	02	Food	Patient Days	1,332,501	31	6,677		42,356	212	2
3	03	Housekeeping	Patient Days	1,332,501	31	14,059		42,356	447	3
4	05	Utilities	Patient Days	1,332,501	31	24,674		42,356	784	4
5	06	Maintenance	Patient Days	1,332,501	31	70,833		42,356	2,252	5
6	17	Administrative	Patient Days	1,332,501	31	74,000		42,356	2,352	6
7	19	Professional Fees	Patient Days	1,332,501	31	138,332		42,356	4,397	7
8	20	Dues and Subscriptions	Patient Days	1,332,501	31	82,842		42,356	2,633	8
9	21	Office and Clerical	Patient Days	1,332,501	31	306,863		42,356	9,754	9
10	24	Seminar and Travel	Patient Days	1,332,501	31	4,580		42,356	146	10
11	25	Other Staff Admin. Trans.	Patient Days	1,332,501	31	11,637		42,356	370	11
12	26	Insurance	Patient Days	1,332,501	31	22,043		42,356	701	12
13	30	Depreciation	Patient Days	1,332,501	31	238,204		42,356	7,572	13
14	32	Interest	Patient Days	1,332,501	31	202,602		42,356	6,440	14
15	33	Real Estate Taxes	Patient Days	1,332,501	31	36,524		42,356	1,161	15
16	34	Rent - Building	Patient Days	1,332,501	31			42,356		16
17	35	Rent - Equipment & Auto	Patient Days	1,332,501	31	90,286		42,356	2,870	17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,331,096	$		$ 42,312	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lakewood Nursing & Rehab Center, Llc # 0046169 Report Period Beginning: 01/01/11 Ending: 12/31/11

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 [X] NO [ ]

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

Name of Related Organization: Extended Care Consulting, LLC
Street Address: 2201 West Main Street
City / State / Zip Code: Evanston, Illinois 60202
Phone Number: (847) 905-3000
Fax Number: (847) 905-3030

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	06	Maintenance (Pooled)	Patient Days	1,332,501	31	187,474	187,474	42,356	5,959	1
2	06	Maintenance (Direct)	Direct		31	122,603	122,603		83	2
3	07	Emp. Ben. - Gen. Serv. (Pooled)	Patient Days	1,332,501	31	33,619		42,356	1,069	3
4	07	Emp. Ben. - Gen. Serv. (Direct)	Direct		31	16,441			12	4
5	12	Admission (Direct)	Direct		31					5
6	15	Emp. Ben. - Nursing (Direct)	Direct		31					6
7	17	Administrative (Pooled)	Patient Days	1,332,501	31	251,959	251,959	42,356	8,009	7
8	21	Office and Clerical (Pooled)	Patient Days	1,332,501	31	2,575,611	2,575,611	42,356	81,871	8
9	21	Office and Clerical (Direct)	Direct		31	545,076	545,076		21,849	9
10	27	Emp. Ben. - Gen. Admin. (Pooled)	Patient Days	1,332,501	31	486,522		42,356	15,465	10
11	27	Emp. Ben. - Gen. Admin. (Direct)	Direct		31	78,893			2,190	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					$ 4,298,198	$ 3,682,723		$ 136,507	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lakewood Nursing & Rehab Center, Llc # 0046169 Report Period Beginning: 01/01/11 Ending: 12/31/11

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 [X] NO [ ]

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

Name of Related Organization: Extended Care Clinical, LLC
Street Address: 2201 West Main Street
City / State / Zip Code: Evanston, Illinois 60202
Phone Number: (847) 905-3000
Fax Number: (847) 905-3030

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	03	Housekeeping	Patient Days	817,528	19	$ 1,549	$	42,356	$ 80	1
2	05	Utilities	Patient Days	817,528	19	2,718		42,356	141	2
3	06	Maintenance	Patient Days	817,528	19	557		42,356	29	3
4	19	Professional Fees	Patient Days	817,528	19	298,695		42,356	15,475	4
5	20	Dues and Subscriptions	Patient Days	817,528	19	2,426		42,356	126	5
6	21	Office & Clerical	Patient Days	817,528	19	44,146		42,356	2,287	6
7	24	Travel and Seminar	Patient Days	817,528	19	29,934		42,356	1,551	7
8	26	Insurance	Patient Days	817,528	19	2,346		42,356	122	8
9	30	Depreciation	Patient Days	817,528	19	22,389		42,356	1,160	9
10	32	Interest	Patient Days	817,528	19	7,100		42,356	368	10
11	33	Real Estate Taxes	Patient Days	817,528	19	4,024		42,356	208	11
12	01	Dietary Salary	Patient Days	817,528	19	119,073	119,073	42,356	6,169	12
13	07	Emp. Ben. - Gen. Serv.	Patient Days	817,528	19	20,044		42,356	1,038	13
14	10	Nursing Salary	Patient Days	817,528	19	664,429	664,429	42,356	34,424	14
15	10a	Rehab Salary	Patient Days	817,528	19			42,356		15
16	12	Social Service Salary	Patient Days	817,528	19	98,474	98,474	42,356	5,102	16
17	15	Emp. Ben. - Healthcare	Patient Days	817,528	19	128,421		42,356	6,653	17
18	17	Administration Salary	Patient Days	817,528	19	578,938	578,938	42,356	29,995	18
19	21	Office Salary	Patient Days	817,528	19	75,625	75,625	42,356	3,918	19
20	27	Emp. Ben. - Gen. Admin.	Patient Days	817,528	19	110,184		42,356	5,709	20
21										21
22										22
23										23
24										24
25	TOTALS					$ 2,211,073	$ 1,536,540		$ 114,555	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lakewood Nursing & Rehab Center, Llc # 0046169 Report Period Beginning: 01/01/11 Ending: 12/31/11

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 [X] NO [ ]

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

Name of Related Organization: Extended Care Clinical, LLC
Street Address: 2201 West Main Street
City / State / Zip Code: Evanston, Illinois 60202
Phone Number: (847) 905-3000
Fax Number: (847) 905-3030

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	01	Dietary Salary	Direct Allocation			$	$		$	1
2	07	Emp. Ben. - General	Direct Allocation							2
3	10	Nursing / Medical Record Salary	Direct Allocation			344,209	344,209		13,547	3
4	12	Social Service / Admission Salary	Direct Allocation			174,668	174,668		8,035	4
5	15	Emp. Ben. - Healthcare	Direct Allocation			61,656			2,035	5
6	17	Administration Salary	Direct Allocation							6
7	27	Emp. Ben. - Gen. Admin.	Direct Allocation							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					$ 580,533	$ 518,877		$ 23,617	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lakewood Nursing & Rehab Center, Llc # 0046169 Report Period Beginning: 01/01/11 Ending: 12/31/11

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 [X] NO [ ]

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

Name of Related Organization: Care Centers Health Systems, Inc.
Street Address: 200 Howard
City / State / Zip Code: Des Plaines, Illinois 60018
Phone Number: (224) 612-5662
Fax Number: (224) 612-5862

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	Dietary Supplies, Supplements	Direct Allocation			$	$		$ 346	1
2	2	Food	Direct Allocation							2
3	10	Nursing Supplies	Direct Allocation						609	3
4	39	Ancillary Expense	Direct Allocation						4,974	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					$	$		$ 5,929	25

Facility Name & ID Number Lakewood Nursing & Rehab Center, Llc # 0046169 Report Period Beginning: 01/01/11 Ending: 12/31/11

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 [X] NO [ ]

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

Name of Related Organization: Xcel Supply, LLC
Street Address: 2201 Main Street
City / State / Zip Code: Evanston, IL 60202
Phone Number: (847)328-7600
Fax Number: (847)328-7615

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	Dietary	Direct Allocation			$	$		$	1
2	3	Housekeeping	Direct Allocation						44,220	2
3	4	Laundry	Direct Allocation						12,614	3
4	6	Repairs & Maintenance	Direct Allocation						302	4
5	10	Nursing	Direct Allocation						107,157	5
6	11	Activities	Direct Allocation							6
7	21	Office And Clerical	Direct Allocation							7
8	22	Employee Benefits	Direct Allocation						2,690	8
9	30	Fixed Assets-Depreciation	Direct Allocation							9
10	39	Ancillary	Direct Allocation						132,374	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					$	$		$ 299,358	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lakewood Nursing & Rehab Center, Llc # 0046169 Report Period Beginning: 01/01/11 Ending: 12/31/11

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 [X] NO [ ]

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

Name of Related Organization: Vent Lease, LLC / CCS Employee Ben. Group, In
Street Address: 2201 W. Main Street
City / State / Zip Code: Evanston, Illinois 60202
Phone Number: (847) 674-1180 / (847)905-4000
Fax Number: (847) 673-7741 / (847)905-4040

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	39	Ventilator Equipment	Direct Allocation						9,612	1
2	39	Other Ancillary	Direct Allocation							2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12	22	Employee Health Insurance	Direct Allocation			$	$		$ 136,067	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					$	$		$ 145,679	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lakewood Nursing & Rehab Center, Llc # 0046169 Report Period Beginning: 01/01/11 Ending: 12/31/11

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 [X] NO [ ]

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

Name of Related Organization: TriCare Rehab
Street Address: 150 Fencl Lane
City / State / Zip Code: Hillside, IL 60162
Phone Number: (773) 449-9400
Fax Number: (773) 449-9700

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	39	Therapy	Direct Allocation			$	$		$ 837,916	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					$	$		$ 837,916	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lakewood Nursing & Rehab Center, Llc # 0046169 Report Period Beginning: 01/01/11 Ending: 12/31/11

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 [X] NO [ ]

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

Name of Related Organization: Reliable Medical of the Midwest, LLC
Street Address: 200 Howard Avenue
City / State / Zip Code: Des Plaines, Illinois 60018-5909
Phone Number: (847) 566-0800
Fax Number: ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	6	R&M - Equipment	Direct Allocation			$	$		$	1
2	10	Nursing Supplies	Direct Allocation							2
3	39	Ancillary Expense	Direct Allocation						5,064	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					$	$		$ 5,064	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lakewood Nursing & Rehab Center, Llc # 0046169 Report Period Beginning: 01/01/11 Ending: 12/31/11

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** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	HFG		X	Note Payable			$	$ 33,243			$ 112	1
2	Rothner Health G II	X									21,540	2
3	Business Partners		X								183,575	3
4	Hunter Management	X									37,596	4
5	See Supplemental Schedule							8,070,157			97,334	5
	Working Capital											
6												6
7												7
8	See Supplemental Schedule											8
9	TOTAL Facility Related						$	$ 8,103,400			$ 340,157	9
	B. Non-Facility Related*											
10	Interest Income		X								(15,855)	10
11	Allocated from EC Consulting	X									6,440	11
12	Allocated from EC Clinical	X									368	12
13	See Supplemental Schedule											13
14	TOTAL Non-Facility Related						$	$			$ (9,047)	14
15	TOTALS (line 9+line14)						$	$ 8,103,400			$ 331,110	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ **None** Line # **N/A**

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

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 Nursing & Rehab Center, Llc # 0046169 Report Period Beginning: 01/01/11 Ending: 12/31/11

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE - SUPPLEMENTAL SCHEDULE

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	Citizens FNB		X				$	$ 8,070,157			$ 156,470	1
2	Rothner Health GII	X									(21,540)	2
3	Hunter Management	X									(37,596)	3
4												4
5												5
6												6
7	TOTAL Long-Term							8,070,157			97,334	7
	Working Capital											
8							$	$			$	8
9												9
10												10
11												11
12												12
13												13
14	TOTAL Working Capital											14
	B. Non-Facility Related*											
15							$	$			$	15
16												16
17												17
18												18
19												19
20	TOTAL Non-Facility Related											20

* 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 Nursing & Rehab Center, Llc **#** 0046169 **Report Period Beginning:** 01/01/11 **Ending:** 12/31/11

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2010 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 104,479	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.)		$ 106,332	2
3. Under or (over) accrual (line 2 minus line 1).		$ 1,853	3
4. Real Estate Tax accrual used for 2011 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 110,211	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.		$ 112,064	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2006	62,342	8
	2007	71,033	9
	2008	76,852	10
	2009	99,504	11
	2010	104,963	12

2011 Accrual-$104,963x1.05=$110,211
Allocated from Extended Care Consulting-$1,161
Allocated from Extended Care Clinical-$208

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2010	$	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.

2010 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Lakewood Nursing & Rehab Center, Llc COUNTY Will

FACILITY IDPH LICENSE NUMBER 0046169

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE (847) 236-1111 FAX #: (847) 236-1155

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2010 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 2010.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	06-03-10-312-003-0000	Long Term Care Property	$ 104,962.74	$ 104,962.74
2.	See Attached	Allocation from 2201 Main	$ 126,481.18	$ 1,911.89
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 231,443.92	$ 106,874.63

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? X YES _____ NO

If YES, attach an explanation and 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 2010 tax bills which were listed in Section A to this statement. Be sure to use the 2010 tax bill which is normally paid during 2011.

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.

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Lakewood Nursing & Rehab Center, Llc COUNTY Will

FACILITY IDPH LICENSE NUMBER 0046169

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 2000 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 2000.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.			$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocations**

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

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

Facility Name & ID Number Lakewood Nursing & Rehab Center, Llc # 0046169 Report Period Beginning: 01/01/11 Ending: 12/31/11

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 15,925 B. General Construction Type: Exterior Brick Frame Steel Number of Stories 1

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (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? [X] (a) Own the Equipment [X] (b) Rent equipment from a Related Organization. [X] (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 [X] 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 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility	273,121	2003	$ 237,379	1
2	Allocated from ECC 2201 Main LLC/EC Clinical 2201 Main			12,395	2
3	TOTALS	273,121		$ 249,774	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lakewood Nursing & Rehab Center, Llc # 0046169 Report Period Beginning: 01/01/11 Ending: 12/31/11

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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	131			1971	$ 2,099,630	$	39	$ 49,105	$ 49,105	$ 441,951	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			2003	11,804		20	695	695	8,654	9
10	Various			2004	41,672		20	2,274	2,274	17,224	10
11	Various			2005	14,592		20	1,287	1,287	8,154	11
12	Various			2006	66,264		20	7,716	7,716	44,504	12
13	Various			2007	40,549		20	2,606	2,606	21,392	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

Facility Name & ID Number Lakewood Nursing & Rehab Center, Llc # 0046169 Report Period Beginning: 01/01/11 Ending: 12/31/11

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 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	Related Building Company (Pages 12F & 12G)		6,332,257	223,402		316,613	93,211	1,922,782	67
68	Related Party Allocations (Pages 12H & 12I)		50,194	3,409		3,409		27,215	68
69	Financial Statement Depreciation			80,983			(80,983)		69
70	TOTAL (lines 4 thru 69)		$ 8,656,961	$ 307,794		$ 383,705	$ 75,911	$ 2,491,876	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 Nursing & Rehab Center, Llc # 0046169 Report Period Beginning: 01/01/11 Ending: 12/31/11

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 8,656,961	$ 307,794		$ 383,705	$ 75,911	$ 2,491,876	1
2	Remove Wallpaper From Walls	2008	2,500		20			2,500	2
3	Alarm System	2008	5,643		20	282	282	1,129	3
4	Plaster & Paint 15 Rooms	2008	7,567		20			7,567	4
5	Painting (Transfer From Home Office)	2008	9,256		20			9,256	5
6	Painting (Transfer From Home Office)	2008	10,036		20			10,036	6
7	New Laundry Room	2008	3,025		20	151	151	529	7
8	Repairs Of Ice Cream Parlor	2008	4,380		20	219	219	730	8
9	Painting (Reclass From Home Office)	2008	4,481		20			4,481	9
10	Painting (Reclass From Home Office)	2008	896		20			896	10
11	Repair Water Line	2008	5,832		20	292	292	948	11
12	Painting (Transfer Expense From Home Office)	2008	6,025		20			6,025	12
13	Painting (Transfer Expense From Home Office)	2008	1,205		20			1,205	13
14	Install Expansion Joint	2008	4,500		20	225	225	713	14
15	Roof Repair	2009	2,650		20	133	133	353	15
16	Painting	2009	7,624		20			7,624	16
17	Painting	2009	6,744		20			6,744	17
18	Painting	2009	4,216		20			4,216	18
19	Painting	2009	4,995		20			4,995	19
20	Ceiling	2009	5,250		20	263	263	569	20
21	Ceiling	2009	6,833		20	342	342	712	21
22	Painting	2009	1,651		20			1,651	22
23	Painting	2009	843		20			843	23
24	Painting	2009	999		20			999	24
25	Furnace	2010	4,036		20	202	202	235	25
26	Repair Roof From Storm Damage	2010	3,100		20	155	155	245	26
27	Repairs To Carrier Varialbe Volume & Temp. Controls System	2010	3,123		20	156	156	234	27
28	Roofing Project	2011	65,295		20	907	907	907	28
29	Commercial Heat Equipment - Water Heater	2011	5,448		20	999	999	999	29
30	Commercial Heat Equipment - Water Heater	2011	2,590		20	345	345	345	30
31	Roof Repairs	2011	2,710		20	136	136	136	31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 8,850,413	$ 307,794		$ 388,510	$ 80,716	$ 2,569,697	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Lakewood Nursing & Rehab Center, Llc # 0046169 Report Period Beginning: 01/01/11 Ending: 12/31/11

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 8,850,413	$ 307,794		$ 388,510	$ 80,716	$ 2,569,697	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
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25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 8,850,413	$ 307,794		$ 388,510	$ 80,716	$ 2,569,697	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Lakewood Nursing & Rehab Center, Llc # 0046169 Report Period Beginning: 01/01/11 Ending: 12/31/11

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 8,850,413	$ 307,794		$ 388,510	$ 80,716	$ 2,569,697	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
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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)		$ 8,850,413	$ 307,794		$ 388,510	$ 80,716	$ 2,569,697	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Lakewood Nursing & Rehab Center, Llc # 0046169 Report Period Beginning: 01/01/11 Ending: 12/31/11

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		$ 8,850,413	$ 307,794		$ 388,510	$ 80,716	$ 2,569,697	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
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25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 8,850,413	$ 307,794		$ 388,510	$ 80,716	$ 2,569,697	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Lakewood Nursing & Rehab Center, Llc # 0046169 Report Period Beginning: 01/01/11 Ending: 12/31/11

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Building Company Information								1
2	Buildings:								2
3									3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Depreciation			223,402			(223,402)		9
10									10
11	Construction Project	2005	1,354,202		20	67,710	67,710	476,794	11
12	Construction Project	2006	4,978,055		20	248,903	248,903	1,445,988	12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
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31									31
32									32
33									33
34									34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Lakewood Nursing & Rehab Center, Llc # 0046169 Report Period Beginning: 01/01/11 Ending: 12/31/11

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Building Company Information Continued		$	$		$	$	$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (12F & 12G lines 1 thru 33)		$ 6,332,257	$ 223,402		$ 316,613	$ 93,211	$ 1,922,782	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Lakewood Nursing & Rehab Center, Llc # 0046169 Report Period Beginning: 01/01/11 Ending: 12/31/11

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Related Party Information		$	$		$	$	$	1
2	Buildings:								2
3	Allocated from Extended Care Consulting 2201 Main LLC	2002	14,481	371	39	371		3,450	3
4	Allocated from Extended Care Clinical 2201 Main LLC	2002	2,600	67	39	67		619	4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Allocated from Extended Care Consulting 2201 Main LLC	2002	11,962	1,093	20	1,093		8,756	9
10	Allocated from Extended Care Consulting 2201 Main LLC	2003	14,097	1,288	20	1,288		10,319	10
11	Allocated from Extended Care Consulting 2201 Main LLC	2005	700	74	20	74		401	11
12	Allocated from Extended Care Consulting 2201 Main LLC	2009	126	6	20	6		19	12
13									13
14	Allocated from Extended Care Consulting	2007	146	7	20	7		37	14
15	Allocated from Extended Care Consulting	2009	87	4	20	4		13	15
16	Allocated from Extended Care Consulting	2010	858	43	20	43		86	16
17	Allocated from Extended Care Consulting	2011	309	15	20	15		15	17
18									18
19	Allocated from Extended Care Clinical 2201 Main LLC	2002	2,148	196	20	196		1,572	19
20	Allocated from Extended Care Clinical 2201 Main LLC	2003	2,531	231	20	231		1,853	20
21	Allocated from Extended Care Clinical 2201 Main LLC	2005	126	13	20	13		72	21
22	Allocated from Extended Care Clinical 2201 Main LLC	2009	23	1	20	1		3	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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Lakewood Nursing & Rehab Center, Llc # 0046169 Report Period Beginning: 01/01/11 Ending: 12/31/11

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Related Party Information Continued								1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (12H & 12I lines 1 thru 33)		$ 50,194	$ 3,409		$ 3,409	$	$ 27,215	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Lakewood Nursing & Rehab Center, Llc # 0046169 Report Period Beginning: 01/01/11 Ending: 12/31/11

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-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	$ 476,632	$ 791	$ 71,052	$ 70,261	10	$ 406,879	71
72	Current Year Purchases	45,485	3,789	4,021	232	10	30,868	72
73	Fully Depreciated Assets	176,802				10	176,802	73
74								74
75	TOTALS	$ 698,919	$ 4,580	$ 75,073	$ 70,493		$ 614,549	75

D. Vehicle Costs. (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		Allocated from EC Consulting	1900	$ 10,221	$ 160	$ 160	$	5	$ 639	76
77		Allocated from EC Clinical	1900	2,896	579	579		5	1,931	77
78										78
79										79
80	TOTALS			$ 13,117	$ 739	$ 739	$		$ 2,570	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)	$ 9,812,223	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 313,113	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 464,322	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 151,209	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 3,186,816	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 Lakewood Nursing & Rehab Center, Llc # 0046169 Report Period Beginning: 01/01/11 Ending: 12/31/11

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

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

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5		Storage Unit Rental			832			5
6								6
7	TOTAL				$ 832 **			7

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: ____ *

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.	/2012	$
13.	/2013	$
14.	/2014	$

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

15. Is Movable equipment rental included in building rental? ☒ YES ☐ NO
16. Rental Amount for movable equipment: $ 4,379 Description: See Attached Schedule
(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.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lakewood Nursing & Rehab Center, Llc # 0046169 Report Period Beginning: 01/01/11 Ending: 12/31/11

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.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		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

Facility Name & ID Number Lakewood Nursing & Rehab Center, Llc # 0046169 Report Period Beginning: 01/01/11 Ending: 12/31/11

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

	1	2	3	4	5	6	7	8	
	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	39 - 03	hrs	$		$ 337,544	$		$ 337,544	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			134,358			134,358	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			407,890			407,890	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 02	# of prescrpts				639,170		639,170	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): See Supplemental					71,076	268,020		339,096	13
14	TOTAL			$		$ 950,868	$ 907,190		$ 1,858,058	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

STATE OF ILLINOIS

Facility Name & ID Number Lakewood Nursing & Rehab Center, Llc **#** 0046169 **Report Period Beginning:** 01/01/11 **Ending:** 12/31/11

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 12/31/11 **(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	$	$ 191	1
2	Cash-Patient Deposits	32,087	32,087	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,590,730	1,590,730	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	332,720	332,720	6
7	Other Prepaid Expenses	3,195	3,195	7
8	Accounts Receivable (owners or related parties)	347,376	160,354	8
9	Other(specify): See Attached Schedule	791,966	879,627	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 3,098,074	$ 2,998,904	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		237,379	13
14	Buildings, at Historical Cost		4,084,382	14
15	Leasehold Improvements, at Historical Cost	274,551	5,299,656	15
16	Equipment, at Historical Cost	513,384	513,384	16
17	Accumulated Depreciation (book methods)	(573,310)	(2,658,274)	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): See Attached Schedule		17,445	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 214,625	$ 7,493,972	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 3,312,699	$ 10,492,876	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 1,182,130	$ 1,182,129	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	24,364	24,364	28
29	Short-Term Notes Payable	33,243	33,243	29
30	Accrued Salaries Payable	168,970	168,970	30
31	Accrued Taxes Payable (excluding real estate taxes)	7,220	7,220	31
32	Accrued Real Estate Taxes(Sch.IX-B)	110,211	110,211	32
33	Accrued Interest Payable		569,121	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached Schedule	72,127	72,127	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,598,265	$ 2,167,385	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		8,070,157	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Attached Schedule			43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$ 8,070,157	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,598,265	$ 10,237,542	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,714,434	$ 255,334	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 3,312,699	$ 10,492,876	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Facility Name & ID Number Lakewood Nursing & Rehab Center, Llc # 0046169 Report Period Beginning: 01/01/11 Ending: 12/31/11

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,548,498	1
2	Restatements (describe):		2
3	**Rounding**	6	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,548,504	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	577,770	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	(411,840)	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)**	$ 165,930	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)**	$ 1,714,434	24 *

*** This must agree with page 17, line 47.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lakewood Nursing & Rehab Center, Llc # 0046169 Report Period Beginning: 01/01/11 Ending: 12/31/11

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.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 10,358,023	1
2	Discounts and Allowances for all Levels	(4,292,341)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 6,065,682	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	3,409,310	6
7	Oxygen	589	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 3,409,899	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	1,133	13
14	Non-Patient Meals	1,292	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	651,048	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	153,302	19
20	Radiology and X-Ray	21,790	20
21	Other Medical Services	220,710	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 1,049,275	23
	D. Non-Operating Revenue		
24	Contributions	50	24
25	Interest and Other Investment Income***	15,855	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 15,905	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	995	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 995	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 10,541,756	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,435,527	31
32	Health Care	3,725,810	32
33	General Administration	1,998,458	33
	B. Capital Expense		
34	Ownership	724,536	34
	C. Ancillary Expense		
35	Special Cost Centers	1,858,058	35
36	Provider Participation Fee	221,597	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 9,963,986	40
41	**Income before Income Taxes (line 30 minus line 40)****	577,770	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 577,770	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 Nursing & Rehab Center, Llc # 0046169 Report Period Beginning: 01/01/11 Ending: 12/31/11

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,982	2,164	$ 93,849	$ 43.37	1
2	Assistant Director of Nursing	1,750	1,868	68,414	36.62	2
3	Registered Nurses	21,297	24,010	695,902	28.98	3
4	Licensed Practical Nurses	29,043	31,464	824,632	26.21	4
5	CNAs & Orderlies	81,589	88,682	1,048,314	11.82	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	11,672	13,077	240,571	18.40	8
9	Activity Director	1,920	2,050	34,882	17.02	9
10	Activity Assistants	8,788	9,530	107,184	11.25	10
11	Social Service Workers	8,898	9,585	197,037	20.56	11
12	Dietician					12
13	Food Service Supervisor	2,270	2,409	46,260	19.20	13
14	Head Cook					14
15	Cook Helpers/Assistants	5,802	6,354	86,927	13.68	15
16	Dishwashers	16,240	17,885	158,558	8.87	16
17	Maintenance Workers	5,234	5,917	113,812	19.23	17
18	Housekeepers	17,199	19,108	194,249	10.17	18
19	Laundry	5,417	5,803	51,383	8.85	19
20	Administrator	2,016	2,208	102,669	46.50	20
21	Assistant Administrator	2,038	2,094	49,857	23.81	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	8,482	9,318	159,751	17.14	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	2,666	3,166	59,080	18.66	31
32	Other Health Care(specify)					32
33	Other(specify) See Supplemental	1,486	1,664	22,005	13.22	33
34	TOTAL (lines 1 - 33)	235,789	258,356	$ 4,355,336 *	$ 16.86	34

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	199	$ 9,138	01-03	35
36	Medical Director	Monthly	24,500	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	7,832	10-03	39
40	Physical Therapy Consultant	Monthly	148	10a-03	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	4	251	12-03	45
46	Other(specify)				46
47					47
48	See Attached		21,582		48
49	TOTAL (lines 35 - 48)	203	$ 63,451		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	70	$ 3,959	10-03	50
51	Licensed Practical Nurses	1,139	47,295	10-03	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	1,209	$ 51,254		53

SEE ACCOUNTANTS' COMPILATION REPORT

* This total must agree with page 4, column 1, line 45.

** See instructions.

Facility Name & ID Number Lakewood Nursing & Rehab Center, Llc # 0046169 Report Period Beginning: 01/01/11 Ending: 12/31/11

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Jeffery Baker (1/1-5/6/11)	Administrator	0	$ 35,239
Shannon Deckinga (5/7-12/31/11)	Administrator	0	67,429
Sharon Flanigan	Asst. Admin	0	49,857
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 152,525

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Extended Care Consultin	Home Office Expense	$ 312,012
Extended Care Clinical	Home Office Expense	104,004
Frost, Ruttenberg, & Rothblatt	Accounting	25,100
See Attached	Legal	37,189
Personnel Planners	Unemployment Consulting	2,405
Blymas	Tax Credit Consulting	3,749
Hamlin & Burton	Liability Management	921
Paycor	Payroll Services	6,344
AIS Assessment & Intelligence	Data Processing	1,269
Ability Network	Data Processing	2,602
eHealth Data Solutions	MDS Software Fee	2,650
See Supplemetal Schedule		38,924
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$ 537,169

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 201,763
Unemployment Compensation Insurance	88,696
FICA Taxes	321,232
Employee Health Insurance	77,351
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Physicals	12,848
Other Employee Welfare	7,719
Holiday Expense	4,539
TOTAL (agree to Schedule V, line 22, col.8)	$ 714,148

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	1,786
Health Care Worker Background Check	2,059
(Indicate # of checks performed 112)	
Patient Background Checks 500	5,000
Dues & Subscriptions	488
License & Fees	1,900
Advertising & Promotions	17,653
Allocated from EC Consulting	2,633
See Supplemental Schedule	126
Less: Public Relations Expense	( )
Non-allowable advertising	(17,653)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 13,992

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	3,880
Allocated from EC Consulting	146
Allocated from EC Clinical	1,551
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 5,577

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lakewood Nursing & Rehab Center, Llc # 0046169 Report Period Beginning: 01/01/11 Ending: 12/31/11

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

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1	N/A		$		$	$	$	$	$	$	$	$	$
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 Nursing & Rehab Center, Llc **#** 0046169 **Report Period Beginning:** 01/01/11 **Ending:** 12/31/11

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. **N/A**

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report? **N/A**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **10 Years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **80,356** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **221,597**
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.

SEE ACCOUNTANTS' COMPILATION REPORT

(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. $ Has any meal income been offset against related costs? **N/A** Indicate the amount. $ **N/A**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **N/A** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **N/A**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: **N/A**

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **Yes**

(19) If total legal fees are in excess of $5,000, have legal invoices and a summary of services performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.