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.

2013
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2013)

I. IDPH License ID Number: 0046169

Facility Name: Lakewood Nrsg & Rehab Center

Address: 14716 S Eastern Ave (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: 2/1/2003

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 01/01/13 to 12/31/13 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 Nrsg & Rehab Center # 0046169 Report Period Beginning: 01/01/13 Ending: 12/31/13

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	26,265	5,158	11,684	43,107	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	26,265	5,158	11,684	43,107	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 90.15%

D. How many bed-hold days during this year were paid by the Department?
None (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 11,083

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: 12/31/2013 Fiscal Year: 12/31/2013

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lakewood Nrsg & Rehab Center # 0046169 Report Period Beginning: 01/01/13 Ending: 12/31/13

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

	Operating Expenses	Costs Per General Ledger: Salary/Wage	Supplies	Other	Total	Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	313,786	67,270	22,004	403,060		403,060	6,707	409,767			1
2	Food Purchase		297,496		297,496		297,496	(561)	296,935			2
3	Housekeeping	196,158	45,085		241,243		241,243	599	241,842			3
4	Laundry	47,291	31,101		78,392		78,392		78,392			4
5	Heat and Other Utilities			183,337	183,337		183,337	791	184,128			5
6	Maintenance	129,036		248,811	377,847		377,847	12,298	390,145			6
7	Other (specify):*							1,990	1,990			7
8	TOTAL General Services	686,271	440,952	454,152	1,581,375		1,581,375	21,825	1,603,200			8
	B. Health Care and Programs											
9	Medical Director			27,600	27,600		27,600		27,600			9
10	Nursing and Medical Records	3,115,485	224,399	68,756	3,408,640		3,408,640	48,894	3,457,534			10
10a	Therapy	186,973		6,587	193,560		193,560		193,560			10a
11	Activities	137,757	34,943		172,700		172,700		172,700			11
12	Social Services	200,396	18		200,414		200,414	21,159	221,573			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*							10,647	10,647			15
16	TOTAL Health Care and Programs	3,640,611	259,360	102,943	4,002,914		4,002,914	80,700	4,083,614			16
	C. General Administration											
17	Administrative	126,592			126,592		126,592	86,292	212,884			17
18	Directors Fees											18
19	Professional Services			601,845	601,845	(94)	601,751	(476,729)	125,022			19
20	Dues, Fees, Subscriptions & Promotions			53,585	53,585		53,585	(28,114)	25,471			20
21	Clerical & General Office Expenses	167,197	32,808	81,374	281,379		281,379	120,895	402,274			21
22	Employee Benefits & Payroll Taxes			824,343	824,343		824,343	(136)	824,207			22
23	Inservice Training & Education											23
24	Travel and Seminar			4,640	4,640		4,640	2,389	7,029			24
25	Other Admin. Staff Transportation			9,301	9,301		9,301	998	10,299			25
26	Insurance-Prop.Liab.Malpractice			264,258	264,258		264,258	1,946	266,204			26
27	Other (specify):*							35,510	35,510			27
28	TOTAL General Administration	293,789	32,808	1,839,346	2,165,943	(94)	2,165,849	(256,950)	1,908,899			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,620,671	733,120	2,396,441	7,750,232	(94)	7,750,138	(154,425)	7,595,713			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 Nrsg & Rehab Center #0046169 Report Period Beginning: 01/01/13 Ending: 12/31/13

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			50,600	50,600		50,600	364,765	415,365			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			2,591	2,591		2,591	483,204	485,795			32
33	Real Estate Taxes			134,618	134,618	94	134,712	3,102	137,814			33
34	Rent-Facility & Grounds			746,608	746,608		746,608	(744,000)	2,608			34
35	Rent-Equipment & Vehicles			1,905	1,905		1,905	944	2,849			35
36	Other (specify):*											36
37	TOTAL Ownership			936,322	936,322	94	936,416	108,015	1,044,431			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		946,628	1,324,179	2,270,807		2,270,807	(27,596)	2,243,211			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			266,189	266,189		266,189		266,189			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		946,628	1,590,368	2,536,996		2,536,996	(27,596)	2,509,400			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	4,620,671	1,679,748	4,923,131	11,223,550		11,223,550	(74,006)	11,149,544			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 Nrsg & Rehab Center # 0046169 Report Period Beginning: 01/01/13 Ending: 12/31/13

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	(176)	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	133,892	30		9
10	Interest and Other Investment Income	(52,834)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(352)	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	(7,192)	21		18
19	Entertainment				19
20	Contributions	(1,250)	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				24
25	Fund Raising, Advertising and Promotional	(25,906)	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	(109,704)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (63,522)		$	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)	(10,485)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (10,485)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (74,006)		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 **Page 5A**

Lakewood Nrsg & Rehab Center

ID# 0046169

Report Period Beginning: 01/01/13

Ending: 12/31/13

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Other Income	$ (60)	21	1
2	Theft Loss	(1,338)	21	2
3	Collection Expense	(6,767)	21	3
4	PPA - Interest	(1,337)	32	4
5	PPA - State Replacement Tax	(41)	21	5
6	COPE Dues	(3,844)	20	6
7	Annual Report	(250)	20	7
8	Bldg Co. - Bank Service Charges	(350)	21	8
9	Bldg Co. - Filing Fees	(250)	21	9
10	Bldg Co. - Amortization	(24,887)	31	10
11	Non Allowable Legal	(10,915)	19	11
12	Vending Income	(529)	02	12
13	Related Party Interest Expense	(59,136)	32	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**	(109,704)		49

Lakewood Nrsg & Rehab Center

ID# 0046169

Report Period Beginning: 01/01/13

Ending: 12/31/13

	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	**Total**	0		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Lakewood Nrsg & Rehab Center # 0046169 **Report Period Beginning:** 01/01/13 **Ending:** 12/31/13

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			282		7,203	(778)						6,707	1
2	Food Purchase	(1,057)		496									(561)	2
3	Housekeeping			497		102							599	3
4	Laundry													4
5	Heat and Other Utilities			656		135							791	5
6	Maintenance			4,286	7,963	49							12,298	6
7	Other (specify):*				895	1,095							1,990	7
8	**TOTAL General Services**	(1,057)		6,217	8,858	8,584	(778)						21,825	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records					48,894							48,894	10
10a	Therapy													10a
11	Activities													11
12	Social Services					21,159							21,159	12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*					10,647							10,647	15
16	**TOTAL Health Care and Programs**					80,700							80,700	16
	C. General Administration													
17	Administrative			3,286	18,143	64,863							86,292	17
18	Directors Fees													18
19	Professional Services	(10,915)		(310,381)		(155,433)							(476,729)	19
20	Fees, Subscriptions & Promotions	(31,250)		2,935		201							(28,114)	20
21	Clerical & General Office Expenses	(15,997)	600	13,872	114,213	8,207							120,895	21
22	Employee Benefits & Payroll Taxes				(136)								(136)	22
23	Inservice Training & Education													23
24	Travel and Seminar			376		2,013							2,389	24
25	Other Admin. Staff Transportation			998									998	25
26	Insurance-Prop.Liab.Malpractice			1,344		602							1,946	26
27	Other (specify):*				24,721	10,789							35,510	27
28	**TOTAL General Administration**	(58,163)	600	(287,570)	156,941	(68,758)							(256,950)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(59,219)	600	(281,353)	165,799	20,526	(778)						(154,425)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Lakewood Nrsg & Rehab Center # 0046169 **Report Period Beginning:** 01/01/13 **Ending:** 12/31/13

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	133,892	223,402	6,041		1,430							364,765	30
31	Amortization of Pre-Op. & Org.	(24,887)	24,887											31
32	Interest	(113,307)	564,142	1,653		30,716							483,204	32
33	Real Estate Taxes			2,572		530							3,102	33
34	Rent-Facility & Grounds		(744,000)										(744,000)	34
35	Rent-Equipment & Vehicles			944									944	35
36	Other (specify):*													36
37	**TOTAL Ownership**	(4,302)	68,431	11,210		32,676							108,015	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers						(1,775)	(1,240)	(24,372)	(208)			(27,596)	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**						(1,775)	(1,240)	(24,372)	(208)			(27,596)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(63,522)	69,031	(270,143)	165,799	53,202	(2,553)	(1,240)	(24,372)	(208)			(74,006)	45

Facility Name & ID Number Lakewood Nrsg & Rehab Center # 0046169 Report Period Beginning: 01/01/13 Ending: 12/31/13

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-Supplemental		

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	Rent	$ 744,000	Lakewood Plainfield Property LLC	100.00%	$	$ (744,000)	1
2	V	33	Rent - R/E Taxes	134,619	Lakewood Plainfield Property LLC	100.00%		(134,619)	2
3	V	32	Interest Income - CIK Investments	6,000	Lakewood Plainfield Property LLC	100.00%		(6,000)	3
4	V	21	Bank Service Charges		Lakewood Plainfield Property LLC	100.00%	350	350	4
5	V	21	Filing Fees		Lakewood Plainfield Property LLC	100.00%	250	250	5
6	V	30	Depreciation		Lakewood Plainfield Property LLC	100.00%	223,402	223,402	6
7	V	31	Amortization		Lakewood Plainfield Property LLC	100.00%	24,887	24,887	7
8	V	33	Real Estate Tax Expense		Lakewood Plainfield Property LLC	100.00%	134,619	134,619	8
9	V	32	Interest - Hunter Mgmt		Lakewood Plainfield Property LLC	100.00%	37,595	37,595	9
10	V	32	Interest - Rothner Health Ventures GII		Lakewood Plainfield Property LLC	100.00%	21,541	21,541	10
11	V	32	Interest - Citizens FNB		Lakewood Plainfield Property LLC	100.00%	511,006	511,006	11
12	V								12
13	V								13
14	Total			$ 884,619			$ 953,650	$ * 69,031	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lakewood Nrsg & Rehab Center # 0046169 Report Period Beginning: 01/01/13 Ending: 12/31/13

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%	$ 282	$ 282	15
16	V	02	Food		Extended Care Consulting, LLC	100.00%	496	496	16
17	V	03	Housekeeping		Extended Care Consulting, LLC	100.00%	497	497	17
18	V	05	Utilities		Extended Care Consulting, LLC	100.00%	656	656	18
19	V	06	Maintenance		Extended Care Consulting, LLC	100.00%	4,286	4,286	19
20	V	17	Administrative		Extended Care Consulting, LLC	100.00%	3,286	3,286	20
21	V	19	Professional Fees	318,720	Extended Care Consulting, LLC	100.00%	8,339	(310,381)	21
22	V	20	Dues and Subscriptions		Extended Care Consulting, LLC	100.00%	2,935	2,935	22
23	V	21	Office and Clerical		Extended Care Consulting, LLC	100.00%	13,872	13,872	23
24	V	24	Seminar and Travel		Extended Care Consulting, LLC	100.00%	376	376	24
25	V	25	Other Staff Admin. Trans.		Extended Care Consulting, LLC	100.00%	998	998	25
26	V	26	Insurance		Extended Care Consulting, LLC	100.00%	1,344	1,344	26
27	V	30	Depreciation		Extended Care Consulting, LLC	100.00%	6,041	6,041	27
28	V	32	Interest		Extended Care Consulting, LLC	100.00%	1,653	1,653	28
29	V	33	Real Estate Taxes		Extended Care Consulting, LLC	100.00%	2,572	2,572	29
30	V	35	Rent - Equipment & Auto		Extended Care Consulting, LLC	100.00%	944	944	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			$ 318,720			$ 48,577	$ * (270,143)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lakewood Nrsg & Rehab Center # 0046169 Report Period Beginning: 01/01/13 Ending: 12/31/13

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%	8,172	$ 8,172	15
16	V	06	Maintenance (Direct)	663	Extended Care Consulting, LLC	100.00%	454	(209)	16
17	V	07	Emp. Ben. - Gen. Serv. (Pooled)		Extended Care Consulting, LLC	100.00%	838	838	17
18	V	07	Emp. Ben. - Gen. Serv. (Direct)		Extended Care Consulting, LLC	100.00%	57	57	18
19	V								19
20	V								20
21	V	17	Administrative (Pooled)		Extended Care Consulting, LLC	100.00%	18,143	18,143	21
22	V	21	Office and Clerical (Pooled)		Extended Care Consulting, LLC	100.00%	114,213	114,213	22
23	V	21	Office and Clerical (Direct)		Extended Care Consulting, LLC	100.00%			23
24	V	27	Emp. Ben. - Gen. Admin. (Pooled)		Extended Care Consulting, LLC	100.00%	24,721	24,721	24
25	V	27	Emp. Ben. - Gen. Admin. (Direct)		Extended Care Consulting, LLC	100.00%			25
26	V	22	Employee Benefits	136	Extended Care Consulting, LLC	100.00%		(136)	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			$ 799			$ 166,598	$ * 165,799	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lakewood Nrsg & Rehab Center # 0046169 Report Period Beginning: 01/01/13 Ending: 12/31/13

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%	$ 102	$ 102	15
16	V	05	Utilities		Extended Care Clinical, LLC	100.00%	135	135	16
17	V	06	Maintenance		Extended Care Clinical, LLC	100.00%	49	49	17
18	V	19	Professional Fees	156,984	Extended Care Clinical, LLC	100.00%	1,551	(155,433)	18
19	V	20	Dues and Subscriptions		Extended Care Clinical, LLC	100.00%	201	201	19
20	V	21	Office & Clerical		Extended Care Clinical, LLC	100.00%	2,083	2,083	20
21	V	24	Travel and Seminar		Extended Care Clinical, LLC	100.00%	2,013	2,013	21
22	V	26	Insurance		Extended Care Clinical, LLC	100.00%	602	602	22
23	V	30	Depreciation		Extended Care Clinical, LLC	100.00%	1,430	1,430	23
24	V	32	Interest		Extended Care Clinical, LLC	100.00%	30,716	30,716	24
25	V	33	Real Estate Taxes		Extended Care Clinical, LLC	100.00%	530	530	25
26	V	01	Dietary Salary		Extended Care Clinical, LLC	100.00%	7,203	7,203	26
27	V	07	Emp. Ben. - Gen. Serv.		Extended Care Clinical, LLC	100.00%	1,095	1,095	27
28	V	10	Nursing Salary		Extended Care Clinical, LLC	100.00%	48,894	48,894	28
29	V	12	Social Service Salary		Extended Care Clinical, LLC	100.00%	21,159	21,159	29
30	V	15	Emp. Ben. - Healthcare		Extended Care Clinical, LLC	100.00%	10,647	10,647	30
31	V	17	Administration Salary		Extended Care Clinical, LLC	100.00%	64,863	64,863	31
32	V	21	Office Salary		Extended Care Clinical, LLC	100.00%	6,124	6,124	32
33	V	27	Emp. Ben. - Gen. Admin.		Extended Care Clinical, LLC	100.00%	10,789	10,789	33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 156,984			$ 210,186	$ * 53,202	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lakewood Nrsg & Rehab Center # 0046169 Report Period Beginning: 01/01/13 Ending: 12/31/13

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	$ 2,778	Care Centers Health Systems, Inc.	100.00%	$ 2,000	$ (778)	15
16	V	10	Nursing Supplies		Care Centers Health Systems, Inc.	100.00%			16
17	V	39	Ancillary Expense	6,341	Care Centers Health Systems, Inc.	100.00%	4,566	(1,775)	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			$ 9,119			$ 6,566	$ * (2,553)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lakewood Nrsg & Rehab Center # 0046169 Report Period Beginning: 01/01/13 Ending: 12/31/13

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	5,980	Vent Lease LLC	100.00%	4,740	(1,240)	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			$ 5,980			$ 4,740	$ * (1,240)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lakewood Nrsg & Rehab Center # 0046169 Report Period Beginning: 01/01/13 Ending: 12/31/13

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	$ 1,259,659	Tri Care Rehab	100.00%	$ 1,235,287	$ (24,372)	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			$ 1,259,659			$ 1,235,287	$ * (24,372)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lakewood Nrsg & Rehab Center # 0046169 Report Period Beginning: 01/01/13 Ending: 12/31/13

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	Ancillary Expense	23,407	Reliable Medical of the Midwest, LLC	100.00%	23,199	$ (208)	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			$ 23,407			$ 23,199	$ * (208)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lakewood Nrsg & Rehab Center # 0046169 Report Period Beginning: 01/01/13 Ending: 12/31/13

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	22	Employee Health Insurance	$	CCS Employee Benefits Group	100.00%	$ 157,940	$ 157,940	15
16	V								16
17	V								17
18	V								18
19	V	22	Employee Health Insurance	157,940	CCS Employee Benefits Group	100.00%		(157,940)	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			$ 157,940			$ 157,940	$ *	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lakewood Nrsg & Rehab Center # 0046169 Report Period Beginning: 01/01/13 Ending: 12/31/13

VII. RELATED PARTIES (continued)

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

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

1 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			$			$	$	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			$			$	$ *	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lakewood Nrsg & Rehab Center # 0046169 Report Period Beginning: 01/01/13 Ending: 12/31/13

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	ROTHNER HEALTH VENTURES G II, LLC	100%	AVENUE CARE NURSING AND REHABILITATION CENTER,LLC	CHICAGO	LAKEWOOD PLAINFIELD PROI	PLAINFIELD	BUILDING CO.	1
2			BEECHER MANOR NURSING AND REHABILITATION CENTER, LLC	BEECHER	EXTENDED CARE CONSULTIN	EVANSTON	MANAGEMENT/BOOKKI	2
3			BOULEVARD CARE NURSING AND REHABILITATION CENTER,LL	CHICAGO	EXTENDED CARE CLINICAL	EVANSTON	ADMINISTRATIVE	3
4			BRIAR PLACE LTD	INDIAN HEAD PARK	CARE CENTER HEALTH SYSTE	DES PLAINES	DIETARY & FOOD SUPPI	4
5			CHATEAU NURSING AND REHABILITATION CENTER, L.L.C.	WILLOWBROOK	C.C.S. VEBA	EVANSTON	HEALTH INSURANCE	5
6			COUNTRYSIDE NURSING AND REHABILITATION CENTER, LLC	DOLTON	ROTHNER VENTS LLC	EVANSTON	VENTALATOR RENTAL	6
7			DYER NURSING & REHAB	DYER, IN	TRICARE REHAB	HILLSIDE	THERAPY	7
8			GRASMERE PLACE, LLC	CHICAGO	RELIABLE MEDICAL SUPPLY C	DES PLAINES	MEDICAL SUPPLY	8
9			LAKE COUNTY NURSING & REHAB	EAST CHICAGO, IN	CARE CENTERS BUILDING LL	EVANSTON	BLDG COMPANY	9
10			LAKEWOOD NURSING & REHABILITATION CENTER, L.L.C.	PLAINFIELD				10
11			LEMONT NURSING AND REHABILITATION CENTER, L.L.C.	LEMONT				11
12			MCKINLEY HEALTH CARE CENTER	CANTON, OH				12
13			OAK PARK HEALTHCARE CENTER, L.L.C.	OAK PARK				13
14			PARC AT JOLIET LLC	JOLIET				14
15			PARK HOUSE NURSING AND REHABILITATION CENTER,LLC	CHICAGO				15
16			PRAIRIE MANOR NURSING & REHABILITATION CENTER, L.L.C.	CHICAGO HEIGHTS				16
17			PRAIRIE VILLAGE HEALTHCARE CENTER, INC.	JACKSONVILLE				17
18			RAINBOW BEACH QOC, L.L.C.	CHICAGO				18
19			SEBOS NURSING & REHAB	HOLBART, IN				19
20			SHEFFIELD MANOR	DYER, IN				20
21			SHERIDAN SHORES CARE & REHABILITATION CENTER, INC.	CHICAGO				21
22			SOUTH SUBURBAN REHABILITATION CENTER, LLC	HOMEWOOD				22
23			TIMBER POINT HEALTHCARE CENTER, INC.	CAMP POINT				23
24			TRI-STATE NURSING & REHABILITATION CENTER, INC.	LANSING				24
25			WHEATON CARE CENTER	WHEATON				25
26								26
27								27
28								28
29								29
30								30

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lakewood Nrsg & Rehab Center # 0046169 Report Period Beginning: 01/01/13 Ending: 12/31/13

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lakewood Nrsg & Rehab Center # 0046169 Report Period Beginning: 01/01/13 Ending: 12/31/13

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	Adam Vales	Relative	Clerical	0.00%	See Attached	1.47	3.68%	Alloc. Salary	$ 2,571	22-7	1
2	Mark Steinberg	Relative	Administrative	0.00%	See Attached	2.85	5.06%	Al Sal/Al Fee	9,935	17-7	2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11	Where applicable, the amounts reported on this page have been adjusted from the actual costs to reflect only the amounts										11
12	anticipated to be considered allowable by the IL. Dept. of HFS.										12
13								TOTAL	$ 12,506		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lakewood Nrsg & Rehab Center # 0046169 Report Period Beginning: 01/01/13 Ending: 12/31/13

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 Nrsg & Rehab Center # 0046169 Report Period Beginning: 01/01/13 Ending: 12/31/13

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	1,101,784	30	$ 7,195	$	43,107	$ 282	1
2	02	Food	Patient Days	1,101,784	30	12,684		43,107	496	2
3	03	Housekeeping	Patient Days	1,101,784	30	12,707		43,107	497	3
4	05	Utilities	Patient Days	1,101,784	30	16,778		43,107	656	4
5	06	Maintenance	Patient Days	1,101,784	30	109,559		43,107	4,286	5
6	17	Administrative	Patient Days	1,101,784	30	84,000		43,107	3,286	6
7	19	Professional Fees	Patient Days	1,101,784	30	213,139		43,107	8,339	7
8	20	Dues and Subscriptions	Patient Days	1,101,784	30	75,016		43,107	2,935	8
9	21	Office and Clerical	Patient Days	1,101,784	30	354,548		43,107	13,872	9
10	24	Seminar and Travel	Patient Days	1,101,784	30	9,615		43,107	376	10
11	25	Other Staff Admin. Trans.	Patient Days	1,101,784	30	25,510		43,107	998	11
12	26	Insurance	Patient Days	1,101,784	30	34,345		43,107	1,344	12
13	30	Depreciation	Patient Days	1,101,784	30	154,393		43,107	6,041	13
14	32	Interest	Patient Days	1,101,784	30	42,261		43,107	1,653	14
15	33	Real Estate Taxes	Patient Days	1,101,784	30	65,749		43,107	2,572	15
16	35	Rent - Equipment & Auto	Patient Days	1,101,784	30	24,117		43,107	944	16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,241,615	$		$ 48,577	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lakewood Nrsg & Rehab Center # 0046169 Report Period Beginning: 01/01/13 Ending: 12/31/13

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	1,101,784	30	208,870	208,870	43,107	8,172	1
2	06	Maintenance (Direct)	Direct		30	331,520	331,520		454	2
3	07	Emp. Ben. - Gen. Serv. (Pooled)	Patient Days	1,101,784	30	21,409		43,107	838	3
4	07	Emp. Ben. - Gen. Serv. (Direct)	Direct		30	37,937			57	4
5										5
6										6
7	17	Administrative (Pooled)	Patient Days	1,101,784	30	463,710	463,710	43,107	18,143	7
8	21	Office and Clerical (Pooled)	Patient Days	1,101,784	30	2,919,199	2,919,199	43,107	114,213	8
9	21	Office and Clerical (Direct)	Direct		30	328,534	328,534			9
10	27	Emp. Ben. - Gen. Admin. (Pooled)	Patient Days	1,101,784	30	631,850		43,107	24,721	10
11	27	Emp. Ben. - Gen. Admin. (Direct)	Direct		30	55,508				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					$ 4,998,538	$ 4,251,833		$ 166,598	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lakewood Nrsg & Rehab Center # 0046169 Report Period Beginning: 01/01/13 Ending: 12/31/13

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 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	610,520	17	$ 1,450	$	43,107	$ 102	1
2	05	Utilities	Patient Days	610,520	17	1,914		43,107	135	2
3	06	Maintenance	Patient Days	610,520	17	698		43,107	49	3
4	19	Professional Fees	Patient Days	610,520	17	21,974		43,107	1,551	4
5	20	Dues and Subscriptions	Patient Days	610,520	17	2,847		43,107	201	5
6	21	Office & Clerical	Patient Days	610,520	17	29,496		43,107	2,083	6
7	24	Travel and Seminar	Patient Days	610,520	17	28,507		43,107	2,013	7
8	26	Insurance	Patient Days	610,520	17	8,533		43,107	602	8
9	30	Depreciation	Patient Days	610,520	17	20,257		43,107	1,430	9
10	32	Interest	Patient Days	610,520	17	435,028		43,107	30,716	10
11	33	Real Estate Taxes	Patient Days	610,520	17	7,502		43,107	530	11
12	01	Dietary Salary	Patient Days	610,520	17	102,014	102,014	43,107	7,203	12
13	07	Emp. Ben. - Gen. Serv.	Patient Days	610,520	17	15,504		43,107	1,095	13
14	10	Nursing Salary	Patient Days	610,520	17	692,482	692,482	43,107	48,894	14
15	12	Social Service Salary	Patient Days	610,520	17	299,672	299,672	43,107	21,159	15
16	15	Emp. Ben. - Healthcare	Patient Days	610,520	17	150,791		43,107	10,647	16
17	17	Administration Salary	Patient Days	610,520	17	918,652	918,652	43,107	64,863	17
18	21	Office Salary	Patient Days	610,520	17	86,739	86,739	43,107	6,124	18
19	27	Emp. Ben. - Gen. Admin.	Patient Days	610,520	17	152,803		43,107	10,789	19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 2,976,862	$ 2,099,559		$ 210,186	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lakewood Nrsg & Rehab Center # 0046169 Report Period Beginning: 01/01/13 Ending: 12/31/13

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			$	$		$ 2,000	1
2	10	Nursing Supplies	Direct Allocation							2
3	39	Ancillary Expense	Direct Allocation						4,566	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					$	$		$ 6,566	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lakewood Nrsg & Rehab Center # 0046169 Report Period Beginning: 01/01/13 Ending: 12/31/13

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
Street Address: 2201 Main Street
City / State / Zip Code: Evanston, Illinois 60202
Phone Number: (847) 674-1180
Fax Number: (847) 673-7741

	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						4,740	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					$	$		$ 4,740	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lakewood Nrsg & Rehab Center # 0046169 Report Period Beginning: 01/01/13 Ending: 12/31/13

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: 240 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			$	$		$ 1,235,287	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					$	$		$ 1,235,287	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lakewood Nrsg & Rehab Center # 0046169 Report Period Beginning: 01/01/13 Ending: 12/31/13

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	39	Ancillary Expense	Direct Allocation						23,199	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					$	$		$ 23,199	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lakewood Nrsg & Rehab Center # 0046169 Report Period Beginning: 01/01/13 Ending: 12/31/13

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: CCS Employee Benefits Group, Inc.
Street Address: 2201 Main Street
City / State / Zip Code: Evanston, Illinois 60202
Phone Number: (847)905-4000
Fax Number: (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	22	Employee Health Insurance	Direct Allocation			$	$		$ 157,940	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					$	$		$ 157,940	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lakewood Nrsg & Rehab Center # 0046169 Report Period Beginning: 01/01/13 Ending: 12/31/13

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization
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 Nrsg & Rehab Center # 0046169 Report Period Beginning: 01/01/13 Ending: 12/31/13

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	Citizens FNB		X				$	$ 7,640,818			$ 511,006	1
2	Hunter Management	X									37,595	2
3	Rothner Health Venture G II	X									21,541	3
4	Hunter Management	X									(37,595)	4
5	See Supplemental Schedule										(21,541)	5
	Working Capital											
6	HFG		X	Note Payable							1,254	6
7												7
8												8
9	TOTAL Facility Related						$	$ 7,640,818			$ 512,260	9
	B. Non-Facility Related*											
10	Interest Income		X								(52,834)	10
11	Interest Income - Bldg Co.		X								(6,000)	11
12	Allocated from EC Clinical	X									30,716	12
13	See Supplemental Schedule										1,653	13
14	TOTAL Non-Facility Related						$	$			$ (26,465)	14
15	TOTALS (line 9+line14)						$	$ 7,640,818			$ 485,795	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 Nrsg & Rehab Center # 0046169 Report Period Beginning: 01/01/13 Ending: 12/31/13

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** 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	Rothner Health Venture G II	X					$	$			$ (21,541)	1
2												2
3												3
4												4
5												5
6												6
7	TOTAL Long-Term										(21,541)	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	Allocated from EC Consulting	X					$	$			$ 1,653	15
16												16
17												17
18												18
19												19
20	TOTAL Non-Facility Related										1,653	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 Nrsg & Rehab Center # 0046169 Report Period Beginning: 01/01/13 Ending: 12/31/13

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2012 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 118,359	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.)		$ 126,506	2
3. Under or (over) accrual (line 2 minus line 1).		$ 8,147	3
4. Real Estate Tax accrual used for 2013 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 129,574	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.)		$ 94	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.		$ 137,815	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2008	76,852	8
	2009	99,504	9
	2010	104,963	10
	2011	112,723	11
	2012	123,404	12

2013 Accrual = $123,404 x 1.05 = $129,574

Allocated from Extended Care Consulting = $2,572

Allocated from Extended Care Clinical = $530

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2012	$	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.

SEE ACCOUNTANTS' COMPILATION REPORT

2012 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Lakewood Nrsg & Rehab Center 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 2012 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 2012.

	(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	$ 123,403.62	$ 123,403.62
2.	See Attached	Allocation from 2201 Main	$ 133,178.74	$ 2,445.72
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 256,582.36	$ 125,849.34

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 2012 tax bills which were listed in Section A to this statement. Be sure to use the 2012 tax bill which is normally paid during 2013.

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.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2012 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Lakewood Nrsg & Rehab Center 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 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 Nrsg & Rehab Center # 0046169 Report Period Beginning: 01/01/13 Ending: 12/31/13

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 Care Centers Building			15,058	2
3	TOTALS	273,121		$ 252,437	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lakewood Nrsg & Rehab Center # 0046169 Report Period Beginning: 01/01/13 Ending: 12/31/13

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	$ 540,161	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			2003	11,804		20	695	695	10,044	9
10	Various			2004	41,672		20	2,162	2,162	21,547	10
11	Various			2005	14,592		20	430	430	9,656	11
12	Various			2006	66,264		20	4,945	4,945	54,919	12
13	Various			2007	40,549		20	1,406	1,406	24,605	13
14	Various			2008	65,346		20	1,169	1,169	48,352	14
15	Various			2009	41,805		20	737	737	30,179	15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

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

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lakewood Nrsg & Rehab Center # 0046169 Report Period Beginning: 01/01/13 Ending: 12/31/13

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	2,556,008	67
68	Related Party Allocations (Pages 12H & 12I)		61,129	4,153		4,153		41,375	68
69	Financial Statement Depreciation			50,600			(50,600)		69
70	TOTAL (lines 4 thru 69)		$ 8,775,047	$ 278,155		$ 381,414	$ 103,259	$ 3,336,846	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 Nrsg & Rehab Center # 0046169 Report Period Beginning: 01/01/13 Ending: 12/31/13

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		$ 8,775,047	$ 278,155		$ 381,414	$ 103,259	$ 3,336,846	1
2	Furnace	2010	4,036		20	202	202	639	2
3	Repair Roof From Storm Damage	2010	3,100		20	155	155	555	3
4	Repairs To Carrier Varialbe Volume & Temp. Controls System	2010	3,123		20	156	156	547	4
5	Roofing Project	2011	65,295		20	1,674	1,674	4,255	5
6	Commercial Heat Equipment - Water Heater	2011	5,448		20	1,090	1,090	3,178	6
7	Commercial Heat Equipment - Water Heater	2011	2,590		20	518	518	1,382	7
8	Roof Repairs	2011	2,710		20	136	136	407	8
9	Abc Supply Co. - Supplies For Roof Replacement	2012	17,702		20	885	885	1,180	9
10	Hugo'S Construction - Roof Replacement	2012	30,781		20	1,539	1,539	2,052	10
11	Schwartz Brothers - Plaster, Prime, Paint Rooms In 400 Wing	2012	3,389		20	169	169	198	11
12	Hot Water Heater Burner & Pipes	2012	2,800		20	140	140	233	12
13	Corridor Double Egress Doors & Metal Doors	2013	5,870		20	269	269	269	13
14	Replace Concrete In Front Of Building	2013	11,760		20	196	196	196	14
15	Install 16 Outlets And Cable Lines In Resident Rooms, Therapy Rc	2013	3,400		20	170	170	170	15
16	Pt Remodel - Shoring Structure, Remove Wall, Relocate Fire Sprin	2013	55,969		20	164	164	164	16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 8,993,019	$ 278,155		$ 388,877	$ 110,722	$ 3,352,270	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 Nrsg & Rehab Center # 0046169 Report Period Beginning: 01/01/13 Ending: 12/31/13

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		$ 8,993,019	$ 278,155		$ 388,877	$ 110,722	$ 3,352,270	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 8,993,019	$ 278,155		$ 388,877	$ 110,722	$ 3,352,270	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 Nrsg & Rehab Center # 0046169 Report Period Beginning: 01/01/13 Ending: 12/31/13

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		$ 8,993,019	$ 278,155		$ 388,877	$ 110,722	$ 3,352,270	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 8,993,019	$ 278,155		$ 388,877	$ 110,722	$ 3,352,270	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 Nrsg & Rehab Center # 0046169 Report Period Beginning: 01/01/13 Ending: 12/31/13

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		$ 8,993,019	$ 278,155		$ 388,877	$ 110,722	$ 3,352,270	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 8,993,019	$ 278,155		$ 388,877	$ 110,722	$ 3,352,270	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 Nrsg & Rehab Center # 0046169 Report Period Beginning: 01/01/13 Ending: 12/31/13

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	612,214	11
12	Construction Project	2006	4,978,055		20	248,903	248,903	1,943,794	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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Lakewood Nrsg & Rehab Center # 0046169 Report Period Beginning: 01/01/13 Ending: 12/31/13

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
13									13
14									14
15									15
16									16
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25									25
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	$ 2,556,008	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 Nrsg & Rehab Center # 0046169 Report Period Beginning: 01/01/13 Ending: 12/31/13

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 Clinical 2201 Main LLC	2002	3,544	91	20	91		1,026	3
4	Allocated from Extended Care Consulting 2201 Main LLC	2002	17,208	441	20	441		4,982	4
5									5
6									6
7									7
8	Leasehold Information								8
9	Allocated from Extended Care Clinical 2201 Main LLC	2002	2,927	268	20	268		2,678	9
10	Allocated from Extended Care Clinical 2201 Main LLC	2003	3,450	315	20	315		3,156	10
11	Allocated from Extended Care Clinical 2201 Main LLC	2005	171	18	20	18		135	11
12	Allocated from Extended Care Clinical 2201 Main LLC	2009	31	2	20	2		8	12
13									13
14	Allocated from Extended Care Consulting	2007	180	9	20	9		63	14
15	Allocated from Extended Care Consulting	2009	108	5	20	5		27	15
16	Allocated from Extended Care Consulting	2010	1,056	53	20	53		211	16
17	Allocated from Extended Care Consulting	2011	380	19	20	19		57	17
18	Allocated from Extended Care Consulting	2012	125	6	20	6		13	18
19									19
20	Allocated from Extended Care Consulting 2201 Main LLC	2002	14,215	1,299	20	1,299		13,003	20
21	Allocated from Extended Care Consulting 2201 Main LLC	2003	16,752	1,531	20	1,531		15,324	21
22	Allocated from Extended Care Consulting 2201 Main LLC	2005	832	88	20	88		654	22
23	Allocated from Extended Care Consulting 2201 Main LLC	2009	150	8	20	8		38	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 Nrsg & Rehab Center # 0046169 Report Period Beginning: 01/01/13 Ending: 12/31/13

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
13									13
14									14
15									15
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22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (12H & 12I lines 1 thru 33)		$ 61,129	$ 4,153		$ 4,153	$	$ 41,375	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 Nrsg & Rehab Center # 0046169 Report Period Beginning: 01/01/13 Ending: 12/31/13

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	$ 159,408	$ 404	$ 17,760	$ 17,356	10	$ 141,317	71
72	Current Year Purchases	51,902	77	5,892	5,815	10	5,892	72
73	Fully Depreciated Assets	573,512	2,110	2,110		10	573,512	73
74								74
75	TOTALS	$ 784,822	$ 2,591	$ 25,762	$ 23,171		$ 720,721	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	2013	$ 6,064	$	$	$	5	$ 6,064	76
77		Allocated from EC Clinical	2013	3,628	726	725	(1)	5	1,072	77
78										78
79										79
80	TOTALS			$ 9,692	$ 726	$ 725	$ (1)		$ 7,136	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)	$ 10,039,970	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 281,472	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 415,364	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 133,892	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 4,080,127	85	

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

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

G. Construction-in-Progress

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lakewood Nrsg & Rehab Center # 0046169 Report Period Beginning: 01/01/13 Ending: 12/31/13

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				2,608			5
6								6
7	TOTAL				$ 2,608 **			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.	/2014	$
13.	/2015	$
14.	/2016	$

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: $ 2,849 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 Nrsg & Rehab Center # 0046169 Report Period Beginning: 01/01/13 Ending: 12/31/13

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 Nrsg & Rehab Center # 0046169 Report Period Beginning: 01/01/13 Ending: 12/31/13

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

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39 - 03	hrs	$		$ 468,833	$		$ 468,833	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			167,180			167,180	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			625,224			625,224	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				631,976		631,976	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					62,942	314,652		377,594	13
14	TOTAL			$		$ 1,324,179	$ 946,628		$ 2,270,807	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 Nrsg & Rehab Center # 0046169 Report Period Beginning: 01/01/13 Ending: 12/31/13

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/13 (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	$ 2,707	$ 22,935	1
2	Cash-Patient Deposits	25,338	25,338	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,455,074	1,455,074	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	341,014	341,014	6
7	Other Prepaid Expenses	2,933	2,933	7
8	Accounts Receivable (owners or related parties)	19,791	(248,770)	8
9	Other(specify): See Attached Schedule	1,707,599	1,707,599	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 3,554,456	$ 3,306,123	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	396,632	5,421,737	15
16	Equipment, at Historical Cost	577,802	577,802	16
17	Accumulated Depreciation (book methods)	(682,056)	(3,213,806)	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):		79,477	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 292,378	$ 7,186,971	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 3,846,834	$ 10,493,094	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 1,763,271	$ 1,763,271	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	24,694	24,694	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	221,389	221,389	30
31	Accrued Taxes Payable (excluding real estate taxes)	10,936	10,936	31
32	Accrued Real Estate Taxes(Sch.IX-B)	129,574	129,574	32
33	Accrued Interest Payable		690,291	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 2,149,864	$ 2,840,155	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		7,640,818	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$ 7,640,818	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 2,149,864	$ 10,480,973	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,696,970	$ 12,121	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 3,846,834	$ 10,493,094	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Facility Name & ID Number Lakewood Nrsg & Rehab Center # 0046169 Report Period Beginning: 01/01/13 Ending: 12/31/13

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total		
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,350,427	1	
2	Restatements (describe):		2	
3	**Rounding**	(2)	3	
4			4	
5			5	
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,350,425	6	
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	346,545	7	
8	Aquisitions of Pooled Companies		8	
9	Proceeds from Sale of Stock		9	
10	Stock Options Exercised		10	
11	Contributions and Grants		11	
12	Expenditures for Specific Purposes		12	
13	Dividends Paid or Other Distributions to Owners	( )	13	
14	Donated Property, Plant, and Equipment		14	
15	Other (describe)		15	
16	Other (describe)		16	
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 346,545	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)**	$ 1,696,970	24	*

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lakewood Nrsg & Rehab Center # 0046169 Report Period Beginning: 01/01/13 Ending: 12/31/13

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.

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 11,341,084	1
2	Discounts and Allowances for all Levels	(6,058,161)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 5,282,923	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	5,119,189	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 5,119,189	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	1,083	13
14	Non-Patient Meals	176	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	634,974	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	234,399	19
20	Radiology and X-Ray	50,269	20
21	Other Medical Services	144,751	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 1,065,652	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	52,834	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 52,834	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	49,497	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 49,497	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 11,570,095	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,581,375	31
32	Health Care	4,002,914	32
33	General Administration	2,165,943	33
	B. Capital Expense		
34	Ownership	936,322	34
	C. Ancillary Expense		
35	Special Cost Centers	2,270,807	35
36	Provider Participation Fee	266,189	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 11,223,550	40
41	**Income before Income Taxes (line 30 minus line 40)****	346,545	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 346,545	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 3,707,297	44
45	Private Pay - Net Inpatient Revenue	980,325	45
46	Medicare - Net Inpatient Revenue	315,042	46
47	Other-(specify) Hospice	251,567	47
48	Other-(specify) Insurance	28,692	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 5,282,923	49

* **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.**

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lakewood Nrsg & Rehab Center # 0046169 Report Period Beginning: 01/01/13 Ending: 12/31/13

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	1,823	2,081	$ 97,459	$ 46.83	1
2	Assistant Director of Nursing	1,583	1,819	69,798	38.37	2
3	Registered Nurses	29,705	32,952	1,029,633	31.25	3
4	Licensed Practical Nurses	23,540	25,606	685,660	26.78	4
5	CNAs & Orderlies	86,175	95,269	1,175,349	12.34	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	9,154	10,255	186,973	18.23	8
9	Activity Director	1,880	2,100	41,673	19.84	9
10	Activity Assistants	7,163	7,777	96,084	12.35	10
11	Social Service Workers	7,497	8,190	200,396	24.47	11
12	Dietician					12
13	Food Service Supervisor	2,456	2,689	54,835	20.39	13
14	Head Cook					14
15	Cook Helpers/Assistants	5,814	6,308	88,002	13.95	15
16	Dishwashers	15,911	17,328	170,949	9.87	16
17	Maintenance Workers	5,927	6,578	129,036	19.62	17
18	Housekeepers	16,943	18,931	196,158	10.36	18
19	Laundry	4,831	5,234	47,291	9.04	19
20	Administrator	2,034	2,182	82,182	37.66	20
21	Assistant Administrator	1,975	2,125	44,410	20.90	21
22	Other Administrative					22
23	Office Manager	1,365	1,375	19,162	13.94	23
24	Clerical	7,146	7,751	148,035	19.10	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	2,365	2,638	54,592	20.69	31
32	Other Health Care(specify)					32
33	Other(specify) See Supplemental	129	201	2,994	14.90	33
34	TOTAL (lines 1 - 33)	235,416	259,389	$ 4,620,671 *	$ 17.81	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	440	$ 22,004	01-03	35
36	Medical Director	Monthly	27,600	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant	Monthly	36,000	10-03	38
39	Pharmacist Consultant	Monthly	10,062	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant	129	6,456	10a-03	42
43	Speech Therapy Consultant	3	131	10a-03	43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	572	$ 102,253		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	174	$ 11,051	10-03	50
51	Licensed Practical Nurses	285	11,643	10-03	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	458	$ 22,694		53

SEE ACCOUNTANTS' COMPILATION REPORT

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

** See instructions.

Facility Name & ID Number Lakewood Nrsg & Rehab Center # 0046169 Report Period Beginning: 01/01/13 Ending: 12/31/13

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Margie Thompson	Administrator	0	$ 82,182
Anna Mohr	Asst Admin	0	44,410
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 126,592

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
Frost, Ruttenberg & Rothblatt	Accounting	$ 25,783
Extended Care Consulting	Home Office Expense	318,720
Extended Care Clincial	Home Office Expense	156,984
Personnel Planners	Unemployment Consult	2,130
Paycor	Payroll Services	25,214
E-Health Data Solutions	MDS Software	3,180
Achieve	Data Processing	12,820
Pro Payroll Solutions	Payroll Services	660
Ability Network	Medicare Billing	161
AIS Assessment & Intelligence	Data Processing	1,100
National Data Corporation	Resident Fund Processing	1,472
See Supplemental Schedule		53,621
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$ 601,845

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 192,663
Unemployment Compensation Insurance	158,635
FICA Taxes	346,998
Employee Health Insurance	102,437
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Physicals	13,463
Other Employee Welfare	7,977
Holiday Expense	2,034
TOTAL (agree to Schedule V, line 22, col.8)	$ 824,207

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	1,802
Health Care Worker Background Check	
(Indicate # of checks performed 324)	3,787
Patient Background Checks	
Dues & Subscriptions	11,408
Licenses & Fees	5,338
Allocated from EC Consulting	2,935
Allocated from EC Clinical	201
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 25,471

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	4,640
Allocated from EC Consulting	376
Allocated from EC Clinical	2,013
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 7,029

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lakewood Nrsg & Rehab Center # 0046169 Report Period Beginning: 01/01/13 Ending: 12/31/13

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 Nrsg & Rehab Center # 0046169 Report Period Beginning: 01/01/13 Ending: 12/31/13

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? **Yes**
If YES, give association name and amount. **IL Council on LTC: $11,648**

(3) Did the nursing home make political contributions or payments to a political action organization? **Yes** If YES, have these costs been properly adjusted out of the cost report? **Yes**

(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. $ **64,657** 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. $ **266,189**
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? **No** 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? **100% Ln 14**
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 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.