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.

2014
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2014)

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 01/01/14 to 12/31/14 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**

Facility Name & ID Number Lakewood Nrsg & Rehab Center # 0046169 Report Period Beginning: 01/01/14 Ending: 12/31/14

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	23,339	6,645	12,065	42,049	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	23,339	6,645	12,065	42,049	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 87.94%

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 10,952

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: 12/31/2014 Fiscal Year: 12/31/2014

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

Facility Name & ID Number Lakewood Nrsg & Rehab Center # 0046169 Report Period Beginning: 01/01/14 Ending: 12/31/14

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	313,656	62,758	20,915	397,329		397,329	4,335	401,664			1
2	Food Purchase		295,177		295,177		295,177	(1,984)	293,193			2
3	Housekeeping	183,931	44,706		228,637		228,637	542	229,179			3
4	Laundry	52,643	20,901		73,544		73,544		73,544			4
5	Heat and Other Utilities			204,572	204,572		204,572	1,187	205,759			5
6	Maintenance	138,083		338,822	476,905		476,905	(67,339)	409,566			6
7	Other (specify):*							1,498	1,498			7
8	TOTAL General Services	688,313	423,542	564,309	1,676,164		1,676,164	(61,761)	1,614,403			8
	B. Health Care and Programs											
9	Medical Director			29,100	29,100		29,100		29,100			9
10	Nursing and Medical Records	3,049,631	310,131	20,774	3,380,536		3,380,536	35,624	3,416,160			10
10a	Therapy	210,043		4,027	214,070		214,070		214,070			10a
11	Activities	139,732	34,010		173,742		173,742		173,742			11
12	Social Services	219,096			219,096		219,096	17,525	236,621			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*							6,417	6,417			15
16	TOTAL Health Care and Programs	3,618,502	344,141	53,901	4,016,544		4,016,544	59,566	4,076,110			16
	C. General Administration											
17	Administrative	136,541			136,541		136,541	79,296	215,837			17
18	Directors Fees											18
19	Professional Services			616,959	616,959	(3,048)	613,911	(458,719)	155,192			19
20	Dues, Fees, Subscriptions & Promotions			57,967	57,967		57,967	(25,964)	32,003			20
21	Clerical & General Office Expenses	169,732	32,482	252,132	454,346		454,346	(84,124)	370,222			21
22	Employee Benefits & Payroll Taxes			925,123	925,123		925,123	(830)	924,293			22
23	Inservice Training & Education											23
24	Travel and Seminar			1,400	1,400		1,400	1,408	2,808			24
25	Other Admin. Staff Transportation			9,206	9,206		9,206	1,153	10,359			25
26	Insurance-Prop.Liab.Malpractice			161,625	161,625		161,625	1,706	163,331			26
27	Other (specify):*							28,993	28,993			27
28	TOTAL General Administration	306,273	32,482	2,024,412	2,363,167	(3,048)	2,360,119	(457,081)	1,903,037			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,613,088	800,165	2,642,622	8,055,875	(3,048)	8,052,827	(459,276)	7,593,550			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.
NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Lakewood Nrsg & Rehab Center #0046169 Report Period Beginning: 01/01/14 Ending: 12/31/14

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			65,494	65,494		65,494	359,127	424,621			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							482,601	482,601			32
33	Real Estate Taxes			115,844	115,844	3,048	118,892	2,644	121,536			33
34	Rent-Facility & Grounds			747,366	747,366		747,366	(744,000)	3,366			34
35	Rent-Equipment & Vehicles			3,447	3,447		3,447	678	4,125			35
36	Other (specify):*											36
37	**TOTAL Ownership**			932,151	932,151	3,048	935,199	101,050	1,036,249			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		972,789	1,356,779	2,329,568		2,329,568	(97,529)	2,232,039			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			214,754	214,754		214,754		214,754			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		972,789	1,571,533	2,544,322		2,544,322	(97,529)	2,446,793			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	4,613,088	1,772,954	5,146,306	11,532,348		11,532,348	(455,756)	11,076,592			45

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

Facility Name & ID Number Lakewood Nrsg & Rehab Center # 0046169 Report Period Beginning: 01/01/14 Ending: 12/31/14

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(1,158)	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	130,822	30		9
10	Interest and Other Investment Income	(45,432)	32		10
11	Discounts, Allowances, Rebates & Refunds	(359)	02		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(461)	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	(1,430)	21		18
19	Entertainment				19
20	Contributions	(404)	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	(198,322)	21		24
25	Fund Raising, Advertising and Promotional	(22,545)	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	(182,369)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (321,658)		$	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)	(134,097)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (134,097)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (455,756)		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

Lakewood Nrsg & Rehab Center

ID# 0046169

Report Period Beginning: 01/01/14

Ending: 12/31/14

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Jury Duty Income	$ (10)	10	1
2	Theft Loss	(1,053)	21	2
3	Collection Expense	(6,972)	21	3
4	Vending Income	(616)	02	4
5	PAC Dues	(2,239)	20	5
6	Annual Report	(250)	20	6
7	Loan Fees	(2,249)	20	7
8	Out of Period Expenses	(1,117)	21	8
9	Non Allowable Legal Fees	(2,544)	19	9
10	Bldg Co. - Management Fee	(1,650)	17	10
11	Bldg Co. - Bank Service Charges	(363)	21	11
12	Bldg Co. - Filing Fees	(250)	20	12
13	Bldg Co. - Amortization	(24,887)	31	13
14	Related Party Interest Expense	(59,136)	32	14
15	Additional Capitalized R&M	(79,034)	06	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**	(182,369)		49

Lakewood Nrsg & Rehab Center

ID# 0046169

Report Period Beginning: 01/01/14

Ending: 12/31/14

	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:** 01/01/14 **Ending:** 12/31/14

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			136		4,199							4,335	1
2	Food Purchase	(2,594)		610									(1,984)	2
3	Housekeeping			456		86							542	3
4	Laundry													4
5	Heat and Other Utilities			1,029		158							1,187	5
6	Maintenance	(79,034)		4,247	7,318	130							(67,339)	6
7	Other (specify):*				1,019	479							1,498	7
8	**TOTAL General Services**	(81,628)		6,478	8,337	5,052							(61,761)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(10)				38,685					(3,051)		35,624	10
10a	Therapy													10a
11	Activities													11
12	Social Services					17,525							17,525	12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*					6,417							6,417	15
16	**TOTAL Health Care and Programs**	(10)				62,627					(3,051)		59,566	16
	C. General Administration													
17	Administrative	(1,650)	1,650	2,822	15,259	61,215							79,296	17
18	Directors Fees													18
19	Professional Services	(2,544)		(340,744)		(115,431)							(458,719)	19
20	Fees, Subscriptions & Promotions	(27,937)	250	1,499		224							(25,964)	20
21	Clerical & General Office Expenses	(209,256)	363	10,267	89,534	24,968							(84,124)	21
22	Employee Benefits & Payroll Taxes				(830)								(830)	22
23	Inservice Training & Education													23
24	Travel and Seminar			235		1,173							1,408	24
25	Other Admin. Staff Transportation			1,153									1,153	25
26	Insurance-Prop.Liab.Malpractice			1,239		467							1,706	26
27	Other (specify):*				19,302	9,691							28,993	27
28	**TOTAL General Administration**	(241,387)	2,263	(323,529)	123,265	(17,693)							(457,081)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(323,025)	2,263	(317,051)	131,602	49,986					(3,051)		(459,276)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Lakewood Nrsg & Rehab Center # 0046169 **Report Period Beginning:** 01/01/14 **Ending:** 12/31/14

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	130,822	223,384	3,818		1,103							359,127	30
31	Amortization of Pre-Op. & Org.	(24,887)	24,887											31
32	Interest	(104,568)	555,043	874		31,252							482,601	32
33	Real Estate Taxes			2,225		419							2,644	33
34	Rent-Facility & Grounds		(744,000)										(744,000)	34
35	Rent-Equipment & Vehicles			678									678	35
36	Other (specify):*													36
37	**TOTAL Ownership**	1,367	59,314	7,595		32,774							101,050	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers						(524)	(93,845)			(3,161)		(97,529)	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**						(524)	(93,845)			(3,161)		(97,529)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(321,658)	61,577	(309,456)	131,602	82,760	(524)	(93,845)			(6,212)		(455,756)	45

Facility Name & ID Number Lakewood Nrsg & Rehab Center # 0046169 Report Period Beginning: 01/01/14 Ending: 12/31/14

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	17	Management Fee		Lakewood Plainfield Property LLC	100.00%	1,650	1,650	2
3	V	21	Bank Service Charges		Lakewood Plainfield Property LLC	100.00%	363	363	3
4	V	20	Filing Fees		Lakewood Plainfield Property LLC	100.00%	250	250	4
5	V	30	Depreciation		Lakewood Plainfield Property LLC	100.00%	223,384	223,384	5
6	V	31	Amortization		Lakewood Plainfield Property LLC	100.00%	24,887	24,887	6
7	V	32	Interest		Lakewood Plainfield Property LLC	100.00%	555,043	555,043	7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 744,000			$ 805,577	$ * 61,577	14

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

Facility Name & ID Number Lakewood Nrsg & Rehab Center # 0046169 Report Period Beginning: 01/01/14 Ending: 12/31/14

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%	$ 136	$ 136	15
16	V	02	Food		Extended Care Consulting, LLC	100.00%	610	610	16
17	V	03	Housekeeping		Extended Care Consulting, LLC	100.00%	456	456	17
18	V	05	Utilities		Extended Care Consulting, LLC	100.00%	1,029	1,029	18
19	V	06	Maintenance		Extended Care Consulting, LLC	100.00%	4,247	4,247	19
20	V	17	Administrative		Extended Care Consulting, LLC	100.00%	2,822	2,822	20
21	V	19	Professional Fees	348,792	Extended Care Consulting, LLC	100.00%	8,048	(340,744)	21
22	V	20	Dues and Subscriptions		Extended Care Consulting, LLC	100.00%	1,499	1,499	22
23	V	21	Office and Clerical		Extended Care Consulting, LLC	100.00%	10,267	10,267	23
24	V	24	Seminar and Travel		Extended Care Consulting, LLC	100.00%	235	235	24
25	V	25	Other Staff Admin. Trans.		Extended Care Consulting, LLC	100.00%	1,153	1,153	25
26	V	26	Insurance		Extended Care Consulting, LLC	100.00%	1,239	1,239	26
27	V	30	Depreciation		Extended Care Consulting, LLC	100.00%	3,818	3,818	27
28	V	32	Interest		Extended Care Consulting, LLC	100.00%	874	874	28
29	V	33	Real Estate Taxes		Extended Care Consulting, LLC	100.00%	2,225	2,225	29
30	V	35	Rent - Equipment & Auto		Extended Care Consulting, LLC	100.00%	678	678	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			$ 348,792			$ 39,336	$ * (309,456)	39

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

Facility Name & ID Number Lakewood Nrsg & Rehab Center # 0046169 Report Period Beginning: 01/01/14 Ending: 12/31/14

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%	7,318	$ 7,318	15
16	V	06	Maintenance (Direct)	2,768	Extended Care Consulting, LLC	100.00%	2,768		16
17	V	07	Emp. Ben. - Gen. Serv. (Pooled)		Extended Care Consulting, LLC	100.00%	694	694	17
18	V	07	Emp. Ben. - Gen. Serv. (Direct)		Extended Care Consulting, LLC	100.00%	325	325	18
19	V								19
20	V								20
21	V	17	Administrative (Pooled)		Extended Care Consulting, LLC	100.00%	15,259	15,259	21
22	V	21	Office and Clerical (Pooled)		Extended Care Consulting, LLC	100.00%	89,534	89,534	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%	19,302	19,302	24
25	V	27	Emp. Ben. - Gen. Admin. (Direct)		Extended Care Consulting, LLC	100.00%			25
26	V	22	Employee Benefits	830	Extended Care Consulting, LLC	100.00%		(830)	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			$ 3,598			$ 135,200	$ * 131,602	39

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

Facility Name & ID Number Lakewood Nrsg & Rehab Center # 0046169 Report Period Beginning: 01/01/14 Ending: 12/31/14

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%	$ 86	$ 86	15
16	V	05	Utilities		Extended Care Clinical, LLC	100.00%	158	158	16
17	V	06	Maintenance		Extended Care Clinical, LLC	100.00%	130	130	17
18	V	19	Professional Fees	116,268	Extended Care Clinical, LLC	100.00%	837	(115,431)	18
19	V	20	Dues and Subscriptions		Extended Care Clinical, LLC	100.00%	224	224	19
20	V	21	Office & Clerical		Extended Care Clinical, LLC	100.00%	1,291	1,291	20
21	V	24	Travel and Seminar		Extended Care Clinical, LLC	100.00%	1,173	1,173	21
22	V	26	Insurance		Extended Care Clinical, LLC	100.00%	467	467	22
23	V	30	Depreciation		Extended Care Clinical, LLC	100.00%	1,103	1,103	23
24	V	32	Interest		Extended Care Clinical, LLC	100.00%	31,252	31,252	24
25	V	33	Real Estate Taxes		Extended Care Clinical, LLC	100.00%	419	419	25
26	V	01	Dietary Salary		Extended Care Clinical, LLC	100.00%	4,199	4,199	26
27	V	07	Emp. Ben. - Gen. Serv.		Extended Care Clinical, LLC	100.00%	479	479	27
28	V	10	Nursing Salary		Extended Care Clinical, LLC	100.00%	38,685	38,685	28
29	V	12	Social Service Salary		Extended Care Clinical, LLC	100.00%	17,525	17,525	29
30	V	15	Emp. Ben. - Healthcare		Extended Care Clinical, LLC	100.00%	6,417	6,417	30
31	V	17	Administration Salary		Extended Care Clinical, LLC	100.00%	61,215	61,215	31
32	V	21	Office Salary		Extended Care Clinical, LLC	100.00%	23,677	23,677	32
33	V	27	Emp. Ben. - Gen. Admin.		Extended Care Clinical, LLC	100.00%	9,691	9,691	33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 116,268			$ 199,028	$ * 82,760	39

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

Facility Name & ID Number Lakewood Nrsg & Rehab Center # 0046169 Report Period Beginning: 01/01/14 Ending: 12/31/14

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	Various Equipment	5,885	Vent Lease LLC	100.00%	5,361	$ (524)	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			$ 5,885			$ 5,361	$ * (524)	39

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

Facility Name & ID Number Lakewood Nrsg & Rehab Center # 0046169 Report Period Beginning: 01/01/14 Ending: 12/31/14

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	$ 1,315,453	Tri Care Rehab	100.00%	$ 1,221,719	$ (93,734)	15
16	V	39	Pharmacy	1,556	Tri Care Rehab	100.00%	1,445	(111)	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			$ 1,317,009			$ 1,223,164	$ * (93,845)	39

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

Facility Name & ID Number Lakewood Nrsg & Rehab Center # 0046169 Report Period Beginning: 01/01/14 Ending: 12/31/14

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%	$ 161,221	$ 161,221	15
16	V								16
17	V								17
18	V								18
19	V	22	Employee Health Insurance	161,221	CCS Employee Benefits Group	100.00%		(161,221)	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			$ 161,221			$ 161,221	$ *	39

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

Facility Name & ID Number Lakewood Nrsg & Rehab Center # 0046169 Report Period Beginning: 01/01/14 Ending: 12/31/14

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	$ 1,909	Care Centers Health Systems, Inc.	100.00%	$ 1,909	$	15
16	V	39	Ancillary Expense	4,662	Care Centers Health Systems, Inc.	100.00%	4,662		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			$ 6,571			$ 6,571	$ *	39

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

Facility Name & ID Number Lakewood Nrsg & Rehab Center # 0046169 Report Period Beginning: 01/01/14 Ending: 12/31/14

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	10	Nursing Supplies / Nursing Equip. Rental	10,835	Reliable Medical of the Midwest, LLC	100.00%	7,784	$ (3,051)	15
16	V	39	Ancillary Expense	11,224	Reliable Medical of the Midwest, LLC	100.00%	8,063	(3,161)	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			$ 22,059			$ 15,847	$ * (6,212)	39

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

Facility Name & ID Number Lakewood Nrsg & Rehab Center # 0046169 Report Period Beginning: 01/01/14 Ending: 12/31/14

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.

Facility Name & ID Number Lakewood Nrsg & Rehab Center # 0046169 Report Period Beginning: 01/01/14 Ending: 12/31/14

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

Facility Name & ID Number Lakewood Nrsg & Rehab Center # 0046169 Report Period Beginning: 01/01/14 Ending: 12/31/14

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1								1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number Lakewood Nrsg & Rehab Center # 0046169 Report Period Beginning: 01/01/14 Ending: 12/31/14

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	1.39	3.48%	Alloc. Salary	$ 2,567	22-7	1
2	Mark Steinberg	Relative	Administrative	0.00%	See Attached	2.48	4.51%	Al Sal/Al Fee	8,998	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	$ 11,565		13

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

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

Facility Name & ID Number Lakewood Nrsg & Rehab Center # 0046169 Report Period Beginning: 01/01/14 Ending: 12/31/14

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

Facility Name & ID Number Lakewood Nrsg & Rehab Center # 0046169 Report Period Beginning: 01/01/14 Ending: 12/31/14

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	1,251,572	31	$ 4,057	$	42,049	$ 136	1
2	02	Food	Patient Days	1,251,572	31	18,150		42,049	610	2
3	03	Housekeeping	Patient Days	1,251,572	31	13,578		42,049	456	3
4	05	Utilities	Patient Days	1,251,572	31	30,626		42,049	1,029	4
5	06	Maintenance	Patient Days	1,251,572	31	126,400		42,049	4,247	5
6	17	Administrative	Patient Days	1,251,572	31	84,000		42,049	2,822	6
7	19	Professional Fees	Patient Days	1,251,572	31	239,560		42,049	8,048	7
8	20	Dues and Subscriptions	Patient Days	1,251,572	31	44,626		42,049	1,499	8
9	21	Office and Clerical	Patient Days	1,251,572	31	305,586		42,049	10,267	9
10	24	Seminar and Travel	Patient Days	1,251,572	31	6,989		42,049	235	10
11	25	Other Staff Admin. Trans.	Patient Days	1,251,572	31	34,307		42,049	1,153	11
12	26	Insurance	Patient Days	1,251,572	31	36,877		42,049	1,239	12
13	30	Depreciation	Patient Days	1,251,572	31	113,642		42,049	3,818	13
14	32	Interest	Patient Days	1,251,572	31	26,010		42,049	874	14
15	33	Real Estate Taxes	Patient Days	1,251,572	31	66,240		42,049	2,225	15
16	35	Rent - Equipment & Auto	Patient Days	1,251,572	31	20,168		42,049	678	16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,170,816	$		$ 39,336	25

Facility Name & ID Number Lakewood Nrsg & Rehab Center # 0046169 Report Period Beginning: 01/01/14 Ending: 12/31/14

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	1,251,572	31	217,811	217,811	42,049	7,318	1
2	06	Maintenance (Direct)	Direct		31	252,781	252,781		2,768	2
3	07	Emp. Ben. - Gen. Serv. (Pooled)	Patient Days	1,251,572	31	20,665		42,049	694	3
4	07	Emp. Ben. - Gen. Serv. (Direct)	Direct		31	33,212			325	4
5										5
6										6
7	17	Administrative (Pooled)	Patient Days	1,251,572	31	454,189	454,189	42,049	15,259	7
8	21	Office and Clerical (Pooled)	Patient Days	1,251,572	31	2,664,951	2,664,951	42,049	89,534	8
9	21	Office and Clerical (Direct)	Direct		31	385,321	385,321			9
10	27	Emp. Ben. - Gen. Admin. (Pooled)	Patient Days	1,251,572	31	574,509		42,049	19,302	10
11	27	Emp. Ben. - Gen. Admin. (Direct)	Direct		31	59,282				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					$ 4,662,721	$ 3,975,053		$ 135,200	25

Facility Name & ID Number Lakewood Nrsg & Rehab Center # 0046169 Report Period Beginning: 01/01/14 Ending: 12/31/14

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	758,409	19	$ 1,549	$	42,049	$ 86	1
2	05	Utilities	Patient Days	758,409	19	2,849		42,049	158	2
3	06	Maintenance	Patient Days	758,409	19	2,348		42,049	130	3
4	19	Professional Fees	Patient Days	758,409	19	15,090		42,049	837	4
5	20	Dues and Subscriptions	Patient Days	758,409	19	4,042		42,049	224	5
6	21	Office & Clerical	Patient Days	758,409	19	23,285		42,049	1,291	6
7	24	Travel and Seminar	Patient Days	758,409	19	21,158		42,049	1,173	7
8	26	Insurance	Patient Days	758,409	19	8,431		42,049	467	8
9	30	Depreciation	Patient Days	758,409	19	19,889		42,049	1,103	9
10	32	Interest	Patient Days	758,409	19	563,670		42,049	31,252	10
11	33	Real Estate Taxes	Patient Days	758,409	19	7,558		42,049	419	11
12	01	Dietary Salary	Patient Days	758,409	19	75,731	75,731	42,049	4,199	12
13	07	Emp. Ben. - Gen. Serv.	Patient Days	758,409	19	8,645		42,049	479	13
14	10	Nursing Salary	Patient Days	758,409	19	697,742	697,742	42,049	38,685	14
15	12	Social Service Salary	Patient Days	758,409	19	316,078	316,078	42,049	17,525	15
16	15	Emp. Ben. - Healthcare	Patient Days	758,409	19	115,731		42,049	6,417	16
17	17	Administration Salary	Patient Days	758,409	19	1,104,097	1,104,097	42,049	61,215	17
18	21	Office Salary	Patient Days	758,409	19	427,044	427,044	42,049	23,677	18
19	27	Emp. Ben. - Gen. Admin.	Patient Days	758,409	19	174,785		42,049	9,691	19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 3,589,719	$ 2,620,691		$ 199,028	25

Facility Name & ID Number Lakewood Nrsg & Rehab Center # 0046169 Report Period Beginning: 01/01/14 Ending: 12/31/14

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	Various Equipment	Direct Allocation						5,361	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					$	$		$ 5,361	25

Facility Name & ID Number Lakewood Nrsg & Rehab Center # 0046169 Report Period Beginning: 01/01/14 Ending: 12/31/14

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			$	$		$ 1,221,719	1
2	39	Pharmacy	Direct Allocation						1,445	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					$	$		$ 1,223,164	25

Facility Name & ID Number Lakewood Nrsg & Rehab Center # 0046169 Report Period Beginning: 01/01/14 Ending: 12/31/14

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			$	$		$ 161,221	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					$	$		$ 161,221	25

Facility Name & ID Number Lakewood Nrsg & Rehab Center # 0046169 Report Period Beginning: 01/01/14 Ending: 12/31/14

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			$	$		$ 1,909	1
2	39	Ancillary Expense	Direct Allocation						4,662	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					$	$		$ 6,571	25

Facility Name & ID Number Lakewood Nrsg & Rehab Center # 0046169 Report Period Beginning: 01/01/14 Ending: 12/31/14

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	10	Nursing Supplies / Nursing Equip	Direct Allocation						7,784	1
2	39	Ancillary Expense	Direct Allocation						8,063	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					$	$		$ 15,847	25

Facility Name & ID Number Lakewood Nrsg & Rehab Center # 0046169 Report Period Beginning: 01/01/14 Ending: 12/31/14

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

Facility Name & ID Number Lakewood Nrsg & Rehab Center # 0046169 Report Period Beginning: 01/01/14 Ending: 12/31/14

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1	Citizens FNB		X	Mortgage			$	$ 7,412,201			$ 495,907	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												6
7												7
8												8
9	TOTAL Facility Related						$	$ 7,412,201			$ 495,907	9
	B. Non-Facility Related*											
10	Interest Income		X								(45,432)	10
11	Allocated from EC Clinical	X									31,252	11
12	Allocated from EC Consulting	X									874	12
13												13
14	TOTAL Non-Facility Related						$	$			$ (13,306)	14
15	TOTALS (line 9+line14)						$	$ 7,412,201			$ 482,601	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.)**

**** 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: 01/01/14 Ending: 12/31/14

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

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related Long-Term											
1	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							$	$			$	15
16												16
17												17
18												18
19												19
20	TOTAL Non-Facility Related											20

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Lakewood Nrsg & Rehab Center **#** 0046169 **Report Period Beginning:** 01/01/14 **Ending:** 12/31/14

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2013 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 129,574	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.)		$ 122,360	2
3. Under or (over) accrual (line 2 minus line 1).		$ (7,214)	3
4. Real Estate Tax accrual used for 2014 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 125,702	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.)**		$ 3,048	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.		$ 121,536	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2009	99,504	8
	2010	104,963	9
	2011	112,723	10
	2012	123,404	11
	2013	119,716	12

2014 Accrual = $119,716 x 1.05 = $125,702

Allocated from Extended Care Consulting = $2,225

Allocated from Extended Care Clinical = $419

FOR BHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2013	$	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.

2013 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 2013 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 2013.

	(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	$ 119,716.20	$ 119,716.20
2.	See Attached	Allocation from 2201 Main	$ 162,082.08	$ 2,518.63
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 281,798.28	$ 122,234.83

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 2013 tax bills which were listed in Section A to this statement. Be sure to use the 2013 tax bill which is normally paid during 2014.

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.

2000 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: 01/01/14 Ending: 12/31/14

X. BUILDING AND GENERAL INFORMATION:

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

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

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

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

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

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

None

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

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

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

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility	273,121	2003	$ 237,379	1
2	Allocated from ECC 2201 Main			12,742	2
3	TOTALS	273,121		$ 250,121	3

Facility Name & ID Number Lakewood Nrsg & Rehab Center # 0046169 Report Period Beginning: 01/01/14 Ending: 12/31/14

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	$ 223,384	39	$ 49,105	$ (174,279)	$ 589,266	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			2003	11,804		20	695	695	10,739	9
10	Various			2004	41,672		20	2,162	2,162	23,709	10
11	Various			2005	14,592		20	430	430	10,086	11
12	Various			2006	66,264		20	4,210	4,210	59,129	12
13	Various			2007	40,549		20	1,406	1,406	26,011	13
14	Various			2008	65,346		20	1,169	1,169	49,521	14
15	Various			2009	41,805		20	737	737	30,916	15
16	Various			2010	10,259		20	513	513	2,254	16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Lakewood Nrsg & Rehab Center # 0046169 Report Period Beginning: 01/01/14 Ending: 12/31/14

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			316,613	316,613	2,872,621	67
68	Related Party Allocations (Pages 12H & 12I)		55,688	3,516		3,516		38,533	68
69	Financial Statement Depreciation			65,494			(65,494)		69
70	TOTAL (lines 4 thru 69)		$ 8,779,864	$ 292,394		$ 380,555	$ 88,161	$ 3,712,784	70

**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: 01/01/14 Ending: 12/31/14

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		$ 8,779,864	$ 292,394		$ 380,555	$ 88,161	$ 3,712,784	1
2	Roofing Project	2011	65,295		20	1,674	1,674	5,930	2
3	Commercial Heat Equipment - Water Heater	2011	5,448		20	1,090	1,090	4,267	3
4	Commercial Heat Equipment - Water Heater	2011	2,590		20	518	518	1,900	4
5	Roof Repairs	2011	2,710		20	136	136	542	5
6	Abc Supply Co. - Supplies For Roof Replacement	2012	17,702		20	885	885	2,065	6
7	Hugo'S Construction - Roof Replacement	2012	30,781		20	1,539	1,539	3,591	7
8	Schwartz Brothers - Plaster, Prime, Paint Rooms In 400 Wing	2012	3,389		20	169	169	367	8
9	Hot Water Heater Burner & Pipes	2012	2,800		20	140	140	373	9
10	Corridor Double Egress Doors & Metal Doors	2013	5,870		20	294	294	563	10
11	Replace Concrete In Front Of Building	2013	11,760		20	588	588	784	11
12	Install 16 Outlets & Cable Lines In Resident Rooms, Therapy Roor	2013	3,400		20	680	680	850	12
13	Pt Remodel-Shoring Structure,Remove Wall,Relocate Fire Sprinkl	2013	55,969		20	2,798	2,798	3,265	13
14	Communication System	2014	35,000		20	1,750	1,750	1,750	14
15	Roofing	2014	6,800		20	312	312	312	15
16	Parking Lot	2014	152,000		20	8,867	8,867	8,867	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)		$ 9,181,378	$ 292,394		$ 401,994	$ 109,600	$ 3,748,209	34

**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: 01/01/14 Ending: 12/31/14

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		$ 9,181,378	$ 292,394		$ 401,994	$ 109,600	$ 3,748,209	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)		$ 9,181,378	$ 292,394		$ 401,994	$ 109,600	$ 3,748,209	34

**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: 01/01/14 Ending: 12/31/14

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		$ 9,181,378	$ 292,394		$ 401,994	$ 109,600	$ 3,748,209	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)		$ 9,181,378	$ 292,394		$ 401,994	$ 109,600	$ 3,748,209	34

**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: 01/01/14 Ending: 12/31/14

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		$ 9,181,378	$ 292,394		$ 401,994	$ 109,600	$ 3,748,209	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)		$ 9,181,378	$ 292,394		$ 401,994	$ 109,600	$ 3,748,209	34

**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: 01/01/14 Ending: 12/31/14

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 12E, Carried Forward		$	$		$	$	$	1
2	Buildings:								2
3									3
4									4
5									5
6									6
7									7
8	Leasehold Improvements								8
9	Depreciation								9
10									10
11	Construction Project	2005	1,354,202		20	67,710	67,710	679,924	11
12	Construction Project	2006	4,978,055		20	248,903	248,903	2,192,697	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)		$ 6,332,257	$		$ 316,613	$ 316,613	$ 2,872,621	34

**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: 01/01/14 Ending: 12/31/14

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 12F, Carried Forward		$ 6,332,257	$		$ 316,613	$ 316,613	$ 2,872,621	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)		$ 6,332,257	$		$ 316,613	$ 316,613	$ 2,872,621	34

**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: 01/01/14 Ending: 12/31/14

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 12G, Carried Forward		$	$		$	$	$	1
2	Buildings:								2
3	Allocated from Extended Care Consulting 2201 Main LLC	2002	14,777	379	39	379		4,657	3
4	Allocated from Extended Care Clinical 2201 Main LLC	2002	2,783	71	39	71		877	4
5									5
6									6
7									7
8	Leasehold Information								8
9	Allocated from Extended Care Consulting	2007	155	8	20	8		62	9
10	Allocated from Extended Care Consulting	2009	92	5	20	5		28	10
11	Allocated from Extended Care Consulting	2010	906	45	20	45		227	11
12	Allocated from Extended Care Consulting	2011	326	16	20	16		65	12
13	Allocated from Extended Care Consulting	2012	108	5	20	5		16	13
14	Allocated from Extended Care Consulting	2014	1,490	75	20	75		75	14
15									15
16	Allocated from Extended Care Consulting 2201 Main LLC	2002	12,207	1,040	20	1,040		12,207	16
17	Allocated from Extended Care Consulting 2201 Main LLC	2003	14,385	1,226	20	1,226		14,385	17
18	Allocated from Extended Care Consulting 2201 Main LLC	2005	715	76	20	76		638	18
19	Allocated from Extended Care Consulting 2201 Main LLC	2009	129	6	20	6		39	19
20	Allocated from Extended Care Consulting 2201 Main LLC	2014	2,060	103	20	103		103	20
21									21
22	Allocated from Extended Care Clinical 2201 Main LLC	2002	2,299	196	20	196		2,299	22
23	Allocated from Extended Care Clinical 2201 Main LLC	2003	2,709	231	20	231		2,709	23
24	Allocated from Extended Care Clinical 2201 Main LLC	2005	135	14	20	14		120	24
25	Allocated from Extended Care Clinical 2201 Main LLC	2009	24	1	20	1		7	25
26	Allocated from Extended Care Clinical 2201 Main LLC	2014	388	19	20	19		19	26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 55,688	$ 3,516		$ 3,516	$	$ 38,533	34

**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: 01/01/14 Ending: 12/31/14

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 12H, Carried Forward		$ 55,688	$ 3,516		$ 3,516	$	$ 38,533	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)		$ 55,688	$ 3,516		$ 3,516	$	$ 38,533	34

**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: 01/01/14 Ending: 12/31/14

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	$ 115,270	$ 414	$ 16,351	$ 15,937	10	$ 67,914	71
72	Current Year Purchases	142,523	249	5,534	5,285	10	5,534	72
73	Fully Depreciated Assets	610,408				10	610,408	73
74								74
75	TOTALS	$ 868,201	$ 663	$ 21,884	$ 21,221		$ 683,856	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	2014	$ 6,063	$ 171	$ 171	$	5	$ 5,378	76
77		Allocated from EC Clinical	2012	2,849	570	570		5	1,412	77
78										78
79										79
80	TOTALS			$ 8,912	$ 741	$ 741	$		$ 6,790	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)	$ 10,308,611	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 293,798	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 424,620	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 130,822	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 4,438,855	85	

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

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

G. Construction-in-Progress

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

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

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

Facility Name & ID Number Lakewood Nrsg & Rehab Center # 0046169 Report Period Beginning: 01/01/14 Ending: 12/31/14

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				3,366			5
6								6
7	TOTAL				$ 3,366 **			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.	/2015	$
13.	/2016	$
14.	/2017	$

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

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO
16. Rental Amount for movable equipment: $ 4,125 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.

Facility Name & ID Number Lakewood Nrsg & Rehab Center # 0046169 Report Period Beginning: 01/01/14 Ending: 12/31/14

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.

Facility Name & ID Number Lakewood Nrsg & Rehab Center # 0046169 Report Period Beginning: 01/01/14 Ending: 12/31/14

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	$		$ 506,477	$		$ 506,477	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			238,810			238,810	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			579,985			579,985	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				772,799		772,799	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					31,507	199,990		231,497	13
14	TOTAL			$		$ 1,356,779	$ 972,789		$ 2,329,568	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number Lakewood Nrsg & Rehab Center # 0046169 Report Period Beginning: 01/01/14 Ending: 12/31/14

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/14 (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	$ 84,491	$ 101,060	1
2	Cash-Patient Deposits	24,329	24,329	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,334,068	1,334,068	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	280,782	280,782	6
7	Other Prepaid Expenses	10,111	10,111	7
8	Accounts Receivable (owners or related parties)	67,762	3,705,303	8
9	Other(specify):	1,665,210	1,665,210	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 3,466,753	$ 7,120,863	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	555,432	5,580,537	15
16	Equipment, at Historical Cost	673,807	673,807	16
17	Accumulated Depreciation (book methods)	(747,550)	(3,502,684)	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):		54,590	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 481,689	$ 7,128,011	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 3,948,442	$ 14,248,874	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 1,665,464	$ 1,665,463	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	21,925	21,925	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	230,538	230,538	30
31	Accrued Taxes Payable (excluding real estate taxes)	12,205	12,205	31
32	Accrued Real Estate Taxes(Sch.IX-B)	125,702	125,702	32
33	Accrued Interest Payable		741,952	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached Schedule	39,546	3,962,252	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 2,095,380	$ 6,760,037	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		7,412,201	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)**	$	$ 7,412,201	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 2,095,380	$ 14,172,238	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,853,062	$ 76,636	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 3,948,442	$ 14,248,874	48

***(See instructions.)**

Facility Name & ID Number Lakewood Nrsg & Rehab Center # 0046169 Report Period Beginning: 01/01/14 Ending: 12/31/14

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total		
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,696,970	1	
2	Restatements (describe):		2	
3	**Misposting of Purchase Redemption in Prior Year**	(1,000)	3	
4	**Rounding**	(3)	4	
5			5	
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,695,967	6	
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	177,682	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	(20,587)	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)**	$ 157,095	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)**	$ 1,853,062	24	*

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

Facility Name & ID Number Lakewood Nrsg & Rehab Center # 0046169 Report Period Beginning: 01/01/14 Ending: 12/31/14

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	$ 11,480,953	1
2	Discounts and Allowances for all Levels	(5,926,178)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 5,554,775	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	5,009,316	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 5,009,316	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	1,101	13
14	Non-Patient Meals	1,158	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	785,407	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	127,283	19
20	Radiology and X-Ray	69,604	20
21	Other Medical Services	114,969	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 1,099,522	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	45,432	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 45,432	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	985	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 985	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 11,710,030	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,676,164	31
32	Health Care	4,016,544	32
33	General Administration	2,363,167	33
	B. Capital Expense		
34	Ownership	932,151	34
	C. Ancillary Expense		
35	Special Cost Centers	2,329,568	35
36	Provider Participation Fee	214,754	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 11,532,348	40
41	**Income before Income Taxes (line 30 minus line 40)****	177,682	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 177,682	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 3,537,080	44
45	Private Pay - Net Inpatient Revenue	1,269,875	45
46	Medicare - Net Inpatient Revenue	471,281	46
47	Other-(specify) Hospice	234,248	47
48	Other-(specify) Insurance	42,291	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 5,554,775	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.**

Facility Name & ID Number Lakewood Nrsg & Rehab Center # 0046169 Report Period Beginning: 01/01/14 Ending: 12/31/14

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	1,985	2,135	$ 93,686	$ 43.88	1
2	Assistant Director of Nursing	1,946	2,160	77,873	36.05	2
3	Registered Nurses	30,524	33,441	1,072,201	32.06	3
4	Licensed Practical Nurses	21,740	24,282	643,743	26.51	4
5	CNAs & Orderlies	77,772	85,127	1,077,415	12.66	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	10,637	11,636	210,043	18.05	8
9	Activity Director	1,988	2,175	44,186	20.32	9
10	Activity Assistants	8,304	8,928	95,546	10.70	10
11	Social Service Workers	8,099	8,936	219,096	24.52	11
12	Dietician					12
13	Food Service Supervisor	1,962	2,128	48,058	22.58	13
14	Head Cook	583	583	11,530	19.78	14
15	Cook Helpers/Assistants	5,832	6,207	91,197	14.69	15
16	Dishwashers	14,916	16,552	162,871	9.84	16
17	Maintenance Workers	6,048	6,904	138,083	20.00	17
18	Housekeepers	15,758	17,622	183,931	10.44	18
19	Laundry	5,226	5,698	52,643	9.24	19
20	Administrator	2,023	2,120	88,147	41.58	20
21	Assistant Administrator	1,964	2,167	48,394	22.33	21
22	Other Administrative					22
23	Office Manager	1,853	1,885	26,572	14.10	23
24	Clerical	6,933	7,526	143,160	19.02	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	2,097	2,359	51,786	21.95	31
32	Other Health Care(specify)					32
33	Other(specify) See Supplemental	1,915	2,131	32,927	15.45	33
34	TOTAL (lines 1 - 33)	230,105	252,702	$ 4,613,088 *	$ 18.26	34

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

** See instructions.

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	415	$ 20,915	01-03	35
36	Medical Director	Monthly	29,100	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant	Monthly	7,500	10-03	38
39	Pharmacist Consultant	Monthly	9,873	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant	81	4,027	10a-03	42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	495	$ 71,415		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	16	$ 928	10-03	50
51	Licensed Practical Nurses	60	2,473	10-03	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	76	$ 3,401		53

Facility Name & ID Number Lakewood Nrsg & Rehab Center # 0046169 Report Period Beginning: 01/01/14 Ending: 12/31/14

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Margie Thompson	Administrator	0	$ 88,147
Anna Mohr	Asst Admin	0	48,394
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 136,541

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	$ 50,236
Extended Care Consulting	Home Office Expense	348,792
Extended Care Clincial	Home Office Expense	116,268
Personnel Planners	Unemployment Consult	2,453
E-Health Data Solutions	MDS Software	2,385
Achieve	Data Processing	14,294
Pro Payroll Solutions	Payroll Services	25,294
IIT/Sourcetech	Data Processing	660
Ability Network	Medicare Billing	1,854
AIS Assessment & Intelligence	Data Processing	1,329
National Data Corporation	Resident Fund Processing	974
See Supplemental Schedule		52,421
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 616,959

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 286,975
Unemployment Compensation Insurance	172,313
FICA Taxes	348,214
Employee Health Insurance	92,636
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Physicals	12,737
Other Employee Welfare	8,182
Holiday Expense	3,236
TOTAL (agree to Schedule V, line 22, col.8)	$ 924,293

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

Description	Line #	Amount
		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 1,990
Advertising: Employee Recruitment	7,710
Health Care Worker Background Check	
(Indicate # of checks performed 250)	3,150
Patient Background Checks	
Dues & Subscriptions	14,622
Licenses & Fees	2,808
Allocated from EC Consulting	1,499
Allocated from EC Clinical	224
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 32,003

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	1,400
Allocated from EC Consulting	235
Allocated from EC Clinical	1,173
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 2,808

**See instructions.

Facility Name & ID Number Lakewood Nrsg & Rehab Center # 0046169 Report Period Beginning: 01/01/14 Ending: 12/31/14

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		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Lakewood Nrsg & Rehab Center # 0046169 Report Period Beginning: 01/01/14 Ending: 12/31/14

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. **ICLTC $6,784 ; Alliance of Healthcare $775**

(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. $ **68,173** 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. $ **214,754**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ 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) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.