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.

2015
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2015)

I. IDPH License ID Number: 0046169

Facility Name: Lakewood Nursing & Rehab Center, Llc

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

County: Will

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

HFS ID Number:

Date of Initial License for Current Owners: 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) 282-6300
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 01/01/15 to 12/31/15 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)
(Firm Name & Address) Marcum, LLP, 111 Pfingsten Road, Suite 300 Deerfield, IL 60015
(Telephone) (847) 282-6300 Fax # (847) 282-6301

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 Nursing & Rehab Center, Llc # 0046169 Report Period Beginning: 01/01/15 Ending: 12/31/15

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	21,827	8,256	12,256	42,339	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	21,827	8,256	12,256	42,339	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 88.55%

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: 12/31/2015 Fiscal Year: 12/31/2015

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

Facility Name & ID Number Lakewood Nursing & Rehab Center, Llc # 0046169 **Report Period Beginning:** 01/01/15 **Ending:** 12/31/15

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	305,056	63,544	21,787	390,387		390,387	7,901	398,288			1
2	Food Purchase		281,471		281,471		281,471	(1,231)	280,240			2
3	Housekeeping	184,618	45,015		229,633		229,633	1,089	230,722			3
4	Laundry	53,802	21,981		75,783		75,783		75,783			4
5	Heat and Other Utilities			196,482	196,482		196,482	1,638	198,120			5
6	Maintenance	131,135		227,156	358,291		358,291	10,270	368,561			6
7	Other (specify):*							2,371	2,371			7
8	**TOTAL General Services**	674,611	412,011	445,425	1,532,047		1,532,047	22,038	1,554,085			8
	B. Health Care and Programs											
9	Medical Director			26,100	26,100		26,100		26,100			9
10	Nursing and Medical Records	3,150,934	394,017	8,741	3,553,692		3,553,692	37,023	3,590,715			10
10a	Therapy	234,919			234,919		234,919		234,919			10a
11	Activities	139,428	30,410		169,838		169,838		169,838			11
12	Social Services	224,211	270		224,481		224,481	22,145	246,626			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*							7,594	7,594			15
16	**TOTAL Health Care and Programs**	3,749,492	424,697	34,841	4,209,030		4,209,030	66,762	4,275,792			16
	C. General Administration											
17	Administrative	119,628			119,628		119,628	77,802	197,430			17
18	Directors Fees											18
19	Professional Services			600,280	600,280	(7,998)	592,282	(481,623)	110,659			19
20	Dues, Fees, Subscriptions & Promotions			90,165	90,165		90,165	(36,078)	54,087			20
21	Clerical & General Office Expenses	177,985	38,664	202,937	419,586		419,586	(41,584)	378,002			21
22	Employee Benefits & Payroll Taxes			848,561	848,561		848,561	(2,211)	846,350			22
23	Inservice Training & Education											23
24	Travel and Seminar			3,118	3,118		3,118	1,294	4,412			24
25	Other Admin. Staff Transportation			9,649	9,649		9,649	1,203	10,852			25
26	Insurance-Prop.Liab.Malpractice			221,151	221,151		221,151	1,707	222,858			26
27	Other (specify):*							27,793	27,793			27
28	**TOTAL General Administration**	297,613	38,664	1,975,861	2,312,138	(7,998)	2,304,140	(451,697)	1,852,443			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	4,721,716	875,372	2,456,127	8,053,215	(7,998)	8,045,217	(362,897)	7,682,319			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 Nursing & Rehab Center, Llc #0046169 Report Period Beginning: 01/01/15 Ending: 12/31/15

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			77,450	77,450		77,450	381,351	458,801			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			34	34		34	456,794	456,828			32
33	Real Estate Taxes			105,237	105,237	7,998	113,235	4,326	117,561			33
34	Rent-Facility & Grounds			746,101	746,101		746,101	(744,000)	2,101			34
35	Rent-Equipment & Vehicles			3,212	3,212		3,212	718	3,930			35
36	Other (specify):*											36
37	**TOTAL Ownership**			932,034	932,034	7,998	940,032	99,189	1,039,222			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		656,417	1,415,838	2,072,255		2,072,255	(3,766)	2,068,489			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			261,346	261,346		261,346		261,346			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		656,417	1,677,184	2,333,601		2,333,601	(3,766)	2,329,835			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	4,721,716	1,531,789	5,065,345	11,318,850		11,318,850	(267,474)	11,051,376			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 Nursing & Rehab Center, Llc # 0046169 Report Period Beginning: 01/01/15 Ending: 12/31/15

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 Reference	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(593)	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	66,443	30		9
10	Interest and Other Investment Income	(31,112)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(538)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(1,042)	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	(154,154)	21		24
25	Fund Raising, Advertising and Promotional	(28,541)	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	(131,494)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (281,030)		$	30

BHF USE ONLY									
48		49		50		51		52	

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

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	13,557		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 13,557		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (267,474)		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 Nursing & Rehab Center, Llc

ID# 0046169

Report Period Beginning: 01/01/15

Ending: 12/31/15

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Pac Dues	$ (6,222)	20	1
2	Annual Report	(250)	20	2
3	Non Allowable Legal Fees	(21,846)	19	3
4	Vending Income	(473)	02	4
5	Patient Clothing	(743)	10	5
6	Theft Loss	(1,386)	21	6
7	Collection Expense	(5,509)	21	7
8	Illinois Replacement Tax	(91)	21	8
9	Bldg Co. - Bank Service Charges	(213)	21	9
10	Bldg Co. - Filing Fees	(250)	20	10
11	Bldg Co. - Amortization	(24,887)	31	11
12	Bldg Co. - Management Fee	(6,600)	17	12
13	Capitalized R&M	(2,689)	06	13
14	Related Party Interest Expense	(59,275)	32	14
15	Joliet Chamber of Commerce Dues	(810)	20	15
16	Plainfield Chamber of Commerce Dues	(250)	20	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**	(131,494)		49

Lakewood Nursing & Rehab Center, Llc

ID# 0046169

Report Period Beginning: 01/01/15

Ending: 12/31/15

	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			49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Lakewood Nursing & Rehab Center, Llc **#** 0046169 **Report Period Beginning:** 01/01/15 **Ending:** 12/31/15

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			140		7,761							7,901	1
2	Food Purchase	(1,604)		373									(1,231)	2
3	Housekeeping			984		105							1,089	3
4	Laundry													4
5	Heat and Other Utilities			1,492		146							1,638	5
6	Maintenance	(2,689)		4,292	8,558	109							10,270	6
7	Other (specify):*				1,390	981							2,371	7
8	**TOTAL General Services**	(4,293)		7,281	9,948	9,102							22,038	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(743)				37,957			(191)				37,023	10
10a	Therapy													10a
11	Activities													11
12	Social Services					22,145							22,145	12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*					7,594							7,594	15
16	**TOTAL Health Care and Programs**	(743)				67,696			(191)				66,762	16
	C. General Administration													
17	Administrative	(6,600)	6,600	2,682	15,006	60,114							77,802	17
18	Directors Fees													18
19	Professional Services	(21,846)		(344,052)		(115,725)							(481,623)	19
20	Fees, Subscriptions & Promotions	(37,365)	250	879		158							(36,078)	20
21	Clerical & General Office Expenses	(161,353)	213	10,978	89,874	18,704							(41,584)	21
22	Employee Benefits & Payroll Taxes				(2,211)								(2,211)	22
23	Inservice Training & Education													23
24	Travel and Seminar			302		992							1,294	24
25	Other Admin. Staff Transportation			1,203									1,203	25
26	Insurance-Prop.Liab.Malpractice			1,227		480							1,707	26
27	Other (specify):*				18,004	9,789							27,793	27
28	**TOTAL General Administration**	(227,164)	7,063	(326,781)	120,673	(25,488)							(451,697)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(232,200)	7,063	(319,500)	130,621	51,310			(191)				(362,897)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Lakewood Nursing & Rehab Center, Llc **#** 0046169 **Report Period Beginning:** 01/01/15 **Ending:** 12/31/15

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	66,443	312,318	1,945		645							381,351	30
31	Amortization of Pre-Op. & Org.	(24,887)	24,887											31
32	Interest	(90,387)	539,175	7,822		184							456,794	32
33	Real Estate Taxes			3,920		406							4,326	33
34	Rent-Facility & Grounds		(744,000)										(744,000)	34
35	Rent-Equipment & Vehicles			718									718	35
36	Other (specify):*													36
37	**TOTAL Ownership**	(48,831)	132,380	14,405		1,235							99,189	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers								(3,766)				(3,766)	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**								(3,766)				(3,766)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(281,030)	139,443	(305,095)	130,621	52,545			(3,957)				(267,474)	45

Facility Name & ID Number Lakewood Nursing & Rehab Center, Llc # 0046169 Report Period Beginning: 01/01/15 Ending: 12/31/15

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	21	Bank Service Charges		Lakewood Plainfield Property LLC	100.00%	213	213	2
3	V	20	Filing Fees		Lakewood Plainfield Property LLC	100.00%	250	250	3
4	V	30	Depreciation		Lakewood Plainfield Property LLC	100.00%	312,318	312,318	4
5	V	31	Amortization		Lakewood Plainfield Property LLC	100.00%	24,887	24,887	5
6	V	32	Interest		Lakewood Plainfield Property LLC	100.00%	539,175	539,175	6
7	V	17	Management Fee		Lakewood Plainfield Property LLC	100.00%	6,600	6,600	7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 744,000			$ 883,443	$ * 139,443	14

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

Facility Name & ID Number Lakewood Nursing & Rehab Center, Llc # 0046169 Report Period Beginning: 01/01/15 Ending: 12/31/15

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%	$ 140	$ 140	15
16	V	02	Food		Extended Care Consulting, LLC	100.00%	373	373	16
17	V	03	Housekeeping		Extended Care Consulting, LLC	100.00%	984	984	17
18	V	05	Utilities		Extended Care Consulting, LLC	100.00%	1,492	1,492	18
19	V	06	Maintenance		Extended Care Consulting, LLC	100.00%	4,292	4,292	19
20	V	17	Administrative		Extended Care Consulting, LLC	100.00%	2,682	2,682	20
21	V	19	Professional Fees	348,792	Extended Care Consulting, LLC	100.00%	4,740	(344,052)	21
22	V	20	Dues and Subscriptions		Extended Care Consulting, LLC	100.00%	879	879	22
23	V	21	Office and Clerical		Extended Care Consulting, LLC	100.00%	10,978	10,978	23
24	V	24	Seminar and Travel		Extended Care Consulting, LLC	100.00%	302	302	24
25	V	25	Other Staff Admin. Trans.		Extended Care Consulting, LLC	100.00%	1,203	1,203	25
26	V	26	Insurance		Extended Care Consulting, LLC	100.00%	1,227	1,227	26
27	V	30	Depreciation		Extended Care Consulting, LLC	100.00%	1,945	1,945	27
28	V	32	Interest		Extended Care Consulting, LLC	100.00%	7,822	7,822	28
29	V	33	Real Estate Taxes		Extended Care Consulting, LLC	100.00%	3,920	3,920	29
30	V	35	Rent - Equipment & Auto		Extended Care Consulting, LLC	100.00%	718	718	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			$ 43,697	$ * (305,095)	39

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

Facility Name & ID Number Lakewood Nursing & Rehab Center, Llc # 0046169 Report Period Beginning: 01/01/15 Ending: 12/31/15

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	06	Maintenance (Pooled)		Extended Care Consulting, LLC	100.00%	8,557	$ 8,557	15
16	V	06	Maintenance (Direct)	7,369	Extended Care Consulting, LLC	100.00%	7,370	1	16
17	V	07	Emp. Ben. - Gen. Serv. (Pooled)		Extended Care Consulting, LLC	100.00%	736	736	17
18	V	07	Emp. Ben. - Gen. Serv. (Direct)		Extended Care Consulting, LLC	100.00%	654	654	18
19	V								19
20	V								20
21	V	17	Administrative (Pooled)		Extended Care Consulting, LLC	100.00%	15,006	15,006	21
22	V	21	Office and Clerical (Pooled)		Extended Care Consulting, LLC	100.00%	89,874	89,874	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%	18,004	18,004	24
25	V	27	Emp. Ben. - Gen. Admin. (Direct)		Extended Care Consulting, LLC	100.00%			25
26	V	22	Employee Benefits	2,211	Extended Care Consulting, LLC	100.00%		(2,211)	26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 9,580			$ 140,201	$ * 130,621	39

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

Facility Name & ID Number Lakewood Nursing & Rehab Center, Llc # 0046169 Report Period Beginning: 01/01/15 Ending: 12/31/15

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%	$ 105	$ 105	15
16	V	05	Utilities		Extended Care Clinical, LLC	100.00%	146	146	16
17	V	06	Maintenance		Extended Care Clinical, LLC	100.00%	109	109	17
18	V	19	Professional Fees	116,268	Extended Care Clinical, LLC	100.00%	543	(115,725)	18
19	V	20	Dues and Subscriptions		Extended Care Clinical, LLC	100.00%	158	158	19
20	V	21	Office & Clerical		Extended Care Clinical, LLC	100.00%	1,344	1,344	20
21	V	24	Travel and Seminar		Extended Care Clinical, LLC	100.00%	992	992	21
22	V	26	Insurance		Extended Care Clinical, LLC	100.00%	480	480	22
23	V	30	Depreciation		Extended Care Clinical, LLC	100.00%	645	645	23
24	V	32	Interest		Extended Care Clinical, LLC	100.00%	184	184	24
25	V	33	Real Estate Taxes		Extended Care Clinical, LLC	100.00%	406	406	25
26	V	01	Dietary Salary		Extended Care Clinical, LLC	100.00%	7,761	7,761	26
27	V	07	Emp. Ben. - Gen. Serv.		Extended Care Clinical, LLC	100.00%	981	981	27
28	V	10	Nursing Salary		Extended Care Clinical, LLC	100.00%	37,957	37,957	28
29	V	12	Social Service Salary		Extended Care Clinical, LLC	100.00%	22,145	22,145	29
30	V	15	Emp. Ben. - Healthcare		Extended Care Clinical, LLC	100.00%	7,594	7,594	30
31	V	17	Administration Salary		Extended Care Clinical, LLC	100.00%	60,114	60,114	31
32	V	21	Office Salary		Extended Care Clinical, LLC	100.00%	17,360	17,360	32
33	V	27	Emp. Ben. - Gen. Admin.		Extended Care Clinical, LLC	100.00%	9,789	9,789	33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 116,268			$ 168,813	$ * 52,545	39

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

Facility Name & ID Number Lakewood Nursing & Rehab Center, Llc # 0046169 Report Period Beginning: 01/01/15 Ending: 12/31/15

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	6,420	Vent Lease LLC	100.00%	6,420	$	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			$ 6,420			$ 6,420	$ *	39

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

Facility Name & ID Number Lakewood Nursing & Rehab Center, Llc # 0046169 Report Period Beginning: 01/01/15 Ending: 12/31/15

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	$ 815,929	Tri Care Rehab	100.00%	$ 815,929	$	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			$ 815,929			$ 815,929	$ *	39

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

Facility Name & ID Number Lakewood Nursing & Rehab Center, Llc # 0046169 Report Period Beginning: 01/01/15 Ending: 12/31/15

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 and Medical Records	$ 14,490	MAC Rx, LLC	100.00%	$ 14,298	$ (191)	15
16	V	39	Ancillary	285,187	MAC Rx, LLC	100.00%	281,422	(3,766)	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			$ 299,677			$ 295,720	$ * (3,957)	39

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

Facility Name & ID Number Lakewood Nursing & Rehab Center, Llc # 0046169 Report Period Beginning: 01/01/15 Ending: 12/31/15

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			$			$	$	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 Nursing & Rehab Center, Llc # 0046169 Report Period Beginning: 01/01/15 Ending: 12/31/15

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 Nursing & Rehab Center, Llc # 0046169 Report Period Beginning: 01/01/15 Ending: 12/31/15

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 Nursing & Rehab Center, Llc # 0046169 Report Period Beginning: 01/01/15 Ending: 12/31/15

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	100.00%	BEECHER MANOR NURSING AND REHABILITATION CENTER, LLC	BEECHER	LAKEWOOD PLAINFIELD PROF	PLAINFIELD	BUILDING CO.	1
2			BRIAR PLACE LTD.	INDIAN HEAD PARK	EXTENDED CARE CONSULTING	EVANSTON	MGMT/BOOKKEEPING	2
3			CHATEAU NURSING AND REHABILITATION CENTER, L.L.C.	WILLOWBROOK	EXTENDED CARE CLINICAL	EVANSTON	CLINICAL	3
4			COUNTRYSIDE NURSING AND REHABILITATION CENTER, LLC	DOLTON	CARE CENTERS BUILDING	EVANSTON	BUILDING CO.	4
5			GRASMERE PLACE, LLC	CHICAGO	VENT LEASE LLC	EVANSTON	VENTILATOR EQIP	5
6			LEMONT NURSING AND REHABILITATION CENTER, L.L.C.	LEMONT	TRI CARE REHAB	HILLSIDE	THERAPY	6
7			MAJOR HOSPITAL DYER	DYER, IN	C.C.S. VEBA	EVANSTON	HEALTH INSURANCE	7
8			MAJOR HOSPITAL LAKE COUNTY	EAST CHICAGO, IN	MAC RX	DES PLAINES	PHARMACY	8
9			MAJOR HOSPITAL LINCOLNSHIRE	MERRIVILLE, IN	RELIABLE MEDICAL SUPPLY	DES PLAINES	MEDICAL SUPPLIES	9
10			MAJOR HOSPITAL MUNSTER	MUNSTER, IN				10
11			MAJOR HOSPITAL SEBOS	HOBART, IN				11
12			MCKINLEY HEALTH CARE CENTER	CANTON, OH				12
13			PARK HOUSE NURSING AND REHABILITATION CENTER,LLC	CHICAGO				13
14			PRAIRIE MANOR NURSING & REHABILITATION CENTER, L.L.C.	CHICAGO HEIGHTS				14
15			PRAIRIE VILLAGE HEALTHCARE CENTER, INC.	JACKSONVILLE				15
16			RAINBOW BEACH QOC, L.L.C.	CHICAGO				16
17			SHEFFIELD MANOR	DYER, IN				17
18			SHERIDAN SHORES CARE & REHABILITATION CENTER, INC.	CHICAGO				18
19			SOUTH SUBURBAN REHABILITATION CENTER, LLC	HOMEWOOD				19
20			SPRING CREEK NURSING & REHAB CENTER	JOLIET				20
21			ST. JAMES WELLNESS REHAB VILLAS	CRETE				21
22			THE ESTATES OF HYDE PARK	CHICAGO				22
23			THE PARC AT JOLIET	JOLIET				23
24			TIMBER POINT HEALTHCARE CENTER, INC.	CAMP POINT				24
25			TRI-STATE NURSING & REHABILITATION CENTER, INC.	LANSING				25
26			WHEATON CARE CENTER	WHEATON				26
27								27
28								28
29								29
30								30

Facility Name & ID Number Lakewood Nursing & Rehab Center, Llc # 0046169 Report Period Beginning: 01/01/15 Ending: 12/31/15

VII. RELATED PARTIES

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

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

Facility Name & ID Number Lakewood Nursing & Rehab Center, Llc # 0046169 Report Period Beginning: 01/01/15 Ending: 12/31/15

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	Mark Steinberg	Relative	Administrative	0.00%	See Attached	2.44	4.44%	Al Sal/Al Fee	9,026	17-7	1
2											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	$ 9,026		13

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

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

Facility Name & ID Number Lakewood Nursing & Rehab Center, Llc # 0046169 Report Period Beginning: 01/01/15 Ending: 12/31/15

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 Nursing & Rehab Center, Llc # 0046169 Report Period Beginning: 01/01/15 Ending: 12/31/15

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	1,326,152	31	$ 4,390	$	42,339	$ 140	1
2	02	Food	Patient Days	1,326,152	31	11,689		42,339	373	2
3	03	Housekeeping	Patient Days	1,326,152	31	30,827		42,339	984	3
4	05	Utilities	Patient Days	1,326,152	31	46,718		42,339	1,492	4
5	06	Maintenance	Patient Days	1,326,152	31	134,435		42,339	4,292	5
6	17	Administrative	Patient Days	1,326,152	31	84,000		42,339	2,682	6
7	19	Professional Fees	Patient Days	1,326,152	31	148,456		42,339	4,740	7
8	20	Dues and Subscriptions	Patient Days	1,326,152	31	27,539		42,339	879	8
9	21	Office and Clerical	Patient Days	1,326,152	31	343,869		42,339	10,978	9
10	24	Seminar and Travel	Patient Days	1,326,152	31	9,455		42,339	302	10
11	25	Other Staff Admin. Trans.	Patient Days	1,326,152	31	37,668		42,339	1,203	11
12	26	Insurance	Patient Days	1,326,152	31	38,431		42,339	1,227	12
13	30	Depreciation	Patient Days	1,326,152	31	60,912		42,339	1,945	13
14	32	Interest	Patient Days	1,326,152	31	244,990		42,339	7,822	14
15	33	Real Estate Taxes	Patient Days	1,326,152	31	122,786		42,339	3,920	15
16	35	Rent - Equipment & Auto	Patient Days	1,326,152	31	22,475		42,339	718	16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,368,640	$		$ 43,697	25

Facility Name & ID Number Lakewood Nursing & Rehab Center, Llc # 0046169 Report Period Beginning: 01/01/15 Ending: 12/31/15

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	1,326,152	31	268,019	268,019	42,339	8,557	1
2	06	Maintenance (Direct)	Direct		31	325,218	325,218		7,370	2
3	07	Emp. Ben. - Gen. Serv. (Pooled)	Patient Days	1,326,152	31	23,065		42,339	736	3
4	07	Emp. Ben. - Gen. Serv. (Direct)	Direct		31	38,919			654	4
5										5
6										6
7	17	Administrative (Pooled)	Patient Days	1,326,152	31	470,018	470,018	42,339	15,006	7
8	21	Office and Clerical (Pooled)	Patient Days	1,326,152	31	2,815,061	2,815,061	42,339	89,874	8
9	21	Office and Clerical (Direct)	Direct		31	402,441	402,441			9
10	27	Emp. Ben. - Gen. Admin. (Pooled)	Patient Days	1,326,152	31	563,937		42,339	18,004	10
11	27	Emp. Ben. - Gen. Admin. (Direct)	Direct		31	58,253				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					$ 4,964,932	$ 4,280,758		$ 140,201	25

Facility Name & ID Number Lakewood Nursing & Rehab Center, Llc # 0046169 Report Period Beginning: 01/01/15 Ending: 12/31/15

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	794,254	19	$ 1,974	$	42,339	$ 105	1
2	05	Utilities	Patient Days	794,254	19	2,745		42,339	146	2
3	06	Maintenance	Patient Days	794,254	19	2,053		42,339	109	3
4	19	Professional Fees	Patient Days	794,254	19	10,180		42,339	543	4
5	20	Dues and Subscriptions	Patient Days	794,254	19	2,961		42,339	158	5
6	21	Office & Clerical	Patient Days	794,254	19	25,207		42,339	1,344	6
7	24	Travel and Seminar	Patient Days	794,254	19	18,605		42,339	992	7
8	26	Insurance	Patient Days	794,254	19	9,008		42,339	480	8
9	30	Depreciation	Patient Days	794,254	19	12,096		42,339	645	9
10	32	Interest	Patient Days	794,254	19	3,455		42,339	184	10
11	33	Real Estate Taxes	Patient Days	794,254	19	7,615		42,339	406	11
12	01	Dietary Salary	Patient Days	794,254	19	145,601	145,601	42,339	7,761	12
13	07	Emp. Ben. - Gen. Serv.	Patient Days	794,254	19	18,397		42,339	981	13
14	10	Nursing Salary	Patient Days	794,254	19	712,051	712,051	42,339	37,957	14
15	12	Social Service Salary	Patient Days	794,254	19	415,434	415,434	42,339	22,145	15
16	15	Emp. Ben. - Healthcare	Patient Days	794,254	19	142,463		42,339	7,594	16
17	17	Administration Salary	Patient Days	794,254	19	1,127,702	1,127,702	42,339	60,114	17
18	21	Office Salary	Patient Days	794,254	19	325,657	325,657	42,339	17,360	18
19	27	Emp. Ben. - Gen. Admin.	Patient Days	794,254	19	183,638		42,339	9,789	19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 3,166,842	$ 2,726,445		$ 168,813	25

Facility Name & ID Number Lakewood Nursing & Rehab Center, Llc # 0046169 Report Period Beginning: 01/01/15 Ending: 12/31/15

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						6,420	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					$	$		$ 6,420	25

Facility Name & ID Number Lakewood Nursing & Rehab Center, Llc # 0046169 Report Period Beginning: 01/01/15 Ending: 12/31/15

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			$	$		$ 815,929	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					$	$		$ 815,929	25

Facility Name & ID Number Lakewood Nursing & Rehab Center, Llc # 0046169 Report Period Beginning: 01/01/15 Ending: 12/31/15

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: MAC Rx, LLC
Street Address: 2307 S. Mount Prospect Road
City / State / Zip Code: Des Plaines, IL 60018
Phone Number: (224)220-2700
Fax Number: (224)220-2730

	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 And Medical Records	Direct Allocation			$	$		$ 14,298	1
2	39	Ancillary	Direct Allocation						281,422	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					$	$		$ 295,720	25

Facility Name & ID Number Lakewood Nursing & Rehab Center, Llc # 0046169 Report Period Beginning: 01/01/15 Ending: 12/31/15

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
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 Nursing & Rehab Center, Llc # 0046169 Report Period Beginning: 01/01/15 Ending: 12/31/15

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 Nursing & Rehab Center, Llc # 0046169 Report Period Beginning: 01/01/15 Ending: 12/31/15

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 Nursing & Rehab Center, Llc # 0046169 Report Period Beginning: 01/01/15 Ending: 12/31/15

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	Citizens FNB		X	Mortgage			$	$ 7,158,159			$ 479,934	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$	$ 7,158,159			$ 479,934	9
	B. Non-Facility Related*											
10	Interest Income		X								(31,112)	10
11	Allocated - EC Consulting	X									7,822	11
12	Allocated - EC Clinical	X									184	12
13												13
14	TOTAL Non-Facility Related						$	$			$ (23,106)	14
15	TOTALS (line 9+line14)						$	$ 7,158,159			$ 456,828	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 Nursing & Rehab Center, Llc # 0046169 Report Period Beginning: 01/01/15 Ending: 12/31/15

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

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
6												6
7	TOTAL Long-Term											7
	Working Capital											
8							$	$			$	8
9												9
10												10
11												11
12												12
13												13
14	TOTAL Working Capital											14
	B. Non-Facility Related*											
15							$	$			$	15
16												16
17												17
18												18
19												19
20	TOTAL Non-Facility Related											20

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Lakewood Nursing & Rehab Center, Llc **#** 0046169 **Report Period Beginning:** 01/01/15 **Ending:** 12/31/15

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2014 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 125,702	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.)		$ 125,475	2
3. Under or (over) accrual (line 2 minus line 1).		$ (227)	3
4. Real Estate Tax accrual used for 2015 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 109,791	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.**		$ 7,998	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.		$ 117,562	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2010	104,963	8
	2011	112,723	9
	2012	123,404	10
	2013	119,716	11
	2014	121,149	12

2015 Accrual is based on the estimated 2015 taxes per the Board of Review
Allocated from Extended Care Consulting = $3,920
Allocated from Extended Care Clinical = $406

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2014	$	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.

2014 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Lakewood Nursing & Rehab Center, Llc COUNTY Will

FACILITY IDPH LICENSE NUMBER 0046169

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

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

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

Enter the tax index number and real estate tax assessed for 2014 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 2014.

	(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	$ 121,148.52	$ 121,148.52
2.	See Attached	Allocated from 2201 W. Main	$ 165,913.23	$ 4,103.27
3.	See Attached	Allocated from 502 Main Street	$ 3,814.66	$ 121.79
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 290,876.41	$ 125,373.58

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 2014 tax bills which were listed in Section A to this statement. Be sure to use the 2014 tax bill which is normally paid during 2015.

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 Nursing & Rehab Center, Llc COUNTY Will

FACILITY IDPH LICENSE NUMBER 0046169

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

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

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

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

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

B. **Real Estate Tax Cost Allocations**

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

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

C. **Tax Bills**

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

Facility Name & ID Number Lakewood Nursing & Rehab Center, Llc # 0046169 Report Period Beginning: 01/01/15 Ending: 12/31/15

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 2201 W. Main, LLC / Clinical			20,280	2
3	TOTALS	273,121		$ 257,659	3

Facility Name & ID Number Lakewood Nursing & Rehab Center, Llc # 0046169 Report Period Beginning: 01/01/15 Ending: 12/31/15

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	$ 312,318	39	$ 53,837	$ (258,481)	$ 643,103	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			2003	11,804		20	425	425	11,164	9
10	Various			2004	41,672		20	2,162	2,162	25,870	10
11	Various			2005	14,592		20	430	430	10,516	11
12	Various			2006	66,264		20	4,210	4,210	63,340	12
13	Various			2007	40,549		20	1,406	1,406	27,417	13
14	Various			2008	65,346		20	1,169	1,169	50,690	14
15	Various			2009	41,805		20	737	737	31,652	15
16	Various			2010	10,259		20	513	513	2,767	16
17	Various			2011	76,043		20	3,417	3,417	16,056	17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Lakewood Nursing & Rehab Center, Llc # 0046169 Report Period Beginning: 01/01/15 Ending: 12/31/15

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	3,189,234	67
68	Related Party Allocations (Pages 12H & 12I)		85,410	1,150		1,150		61,172	68
69	Financial Statement Depreciation			77,450			(77,450)		69
70	TOTAL (lines 4 thru 69)		$ 8,885,629	$ 390,918		$ 386,068	$ (4,850)	$ 4,132,980	70

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

Facility Name & ID Number Lakewood Nursing & Rehab Center, Llc # 0046169 Report Period Beginning: 01/01/15 Ending: 12/31/15

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		$ 8,885,629	$ 390,918		$ 386,068	$ (4,850)	$ 4,132,980	1
2	Abc Supply Co. - Supplies For Roof Replacement	2012	17,702		20	885	885	2,950	2
3	Hugo'S Construction - Roof Replacement	2012	30,781		20	1,539	1,539	5,130	3
4	Schwartz Brothers - Plaster, Prime, Paint Rooms In 400 Wing	2012	3,389		20	169	169	537	4
5	Hot Water Heater Burner & Pipes	2012	2,800		20	140	140	513	5
6	Corridor Double Egress Doors & Metal Doors	2013	5,870		20	294	294	856	6
7	Replace Concrete In Front Of Building	2013	11,760		20	588	588	1,372	7
8	Install 16 Outlets & Cable Lines In Resident Rooms, Therapy Roo	2013	3,400		20	680	680	1,530	8
9	Pt Remodel-Shoring Structure,Remove Wall,Relocate Fire Sprink	2013	55,969		20	2,798	2,798	6,063	9
10	Communication System	2014	35,000		20	7,000	7,000	14,000	10
11	Roofing	2014	6,800		20	340	340	652	11
12	Parking Lot	2014	152,000		20	15,200	15,200	24,067	12
13	Hot Water Tank & Piping	2015	3,520		20	15	15	15	13
14	Sprinkler System Upgrade	2015	2,689		20	134	134	134	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)		$ 9,217,308	$ 390,918		$ 415,851	$ 24,933	$ 4,190,799	34

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

Facility Name & ID Number Lakewood Nursing & Rehab Center, Llc # 0046169 Report Period Beginning: 01/01/15 Ending: 12/31/15

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		$ 9,217,308	$ 390,918		$ 415,851	$ 24,933	$ 4,190,799	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)		$ 9,217,308	$ 390,918		$ 415,851	$ 24,933	$ 4,190,799	34

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

Facility Name & ID Number Lakewood Nursing & Rehab Center, Llc # 0046169 Report Period Beginning: 01/01/15 Ending: 12/31/15

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		$ 9,217,308	$ 390,918		$ 415,851	$ 24,933	$ 4,190,799	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
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 9,217,308	$ 390,918		$ 415,851	$ 24,933	$ 4,190,799	34

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

Facility Name & ID Number Lakewood Nursing & Rehab Center, Llc # 0046169 Report Period Beginning: 01/01/15 Ending: 12/31/15

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		$ 9,217,308	$ 390,918		$ 415,851	$ 24,933	$ 4,190,799	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
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22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 9,217,308	$ 390,918		$ 415,851	$ 24,933	$ 4,190,799	34

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

Facility Name & ID Number Lakewood Nursing & Rehab Center, Llc # 0046169 Report Period Beginning: 01/01/15 Ending: 12/31/15

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Building Company		$	$		$	$	$	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	747,634	11
12	Construction Project	2006	4,978,055		20	248,903	248,903	2,441,600	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	$ 3,189,234	34

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

Facility Name & ID Number Lakewood Nursing & Rehab Center, Llc # 0046169 Report Period Beginning: 01/01/15 Ending: 12/31/15

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	$ 3,189,234	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 6,332,257	$		$ 316,613	$ 316,613	$ 3,189,234	34

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

Facility Name & ID Number Lakewood Nursing & Rehab Center, Llc # 0046169 Report Period Beginning: 01/01/15 Ending: 12/31/15

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Related Party		$	$		$	$	$	1
2	Buildings:								2
3	Allocated from 2201 W. Main, LLC	2002	25,247	647	39	647		8,605	3
4									4
5	Allocated from Extended Care Clinical, LLC	2002	2,699	69	39	69			5
6									6
7									7
8	Leasehold Improvements:								8
9	Allocated from Extended Care Consulting, LLC	2007	147	7	20	7		66	9
10	Allocated from Extended Care Consulting, LLC	2009	88	4	20	4		31	10
11	Allocated from Extended Care Consulting, LLC	2010	861	43	20	43		258	11
12	Allocated from Extended Care Consulting, LLC	2011	310	16	20	16		78	12
13	Allocated from Extended Care Consulting, LLC	2012	102	5	20	5		20	13
14	Allocated from Extended Care Consulting, LLC	2014	1,416	71	20	71		142	14
15									15
16	Allocated from 2201 W. Main, LLC	2002	20,856		20			20,856	16
17	Allocated from 2201 W. Main, LLC	2003	24,578		20			24,578	17
18	Allocated from 2201 W. Main, LLC	2005	1,221	130	20	130		1,219	18
19	Allocated from 2201 W. Main, LLC	2009	220	11	20	11		77	19
20	Allocated from 2201 W. Main, LLC	2014	2,049	102	20	102		205	20
21	Allocated from 2201 W. Main, LLC	2015	347	17	20	17		17	21
22									22
23	Allocated from Extended Care Clinical, LLC	2002	2,230		20			2,230	23
24	Allocated from Extended Care Clinical, LLC	2003	2,628		20			2,628	24
25	Allocated from Extended Care Clinical, LLC	2005	131	14	20	14		130	25
26	Allocated from Extended Care Clinical, LLC	2009	24	1	20	1		8	26
27	Allocated from Extended Care Clinical, LLC	2014	219	11	20	11		22	27
28	Allocated from Extended Care Clinical, LLC	2015	37	2	20	2		2	28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 85,410	$ 1,150		$ 1,150	$	$ 61,172	34

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

Facility Name & ID Number Lakewood Nursing & Rehab Center, Llc # 0046169 Report Period Beginning: 01/01/15 Ending: 12/31/15

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		$ 85,410	$ 1,150		$ 1,150	$	$ 61,172	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 85,410	$ 1,150		$ 1,150	$	$ 61,172	34

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

Facility Name & ID Number Lakewood Nursing & Rehab Center, Llc # 0046169 Report Period Beginning: 01/01/15 Ending: 12/31/15

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	$ 223,860	$ 629	$ 42,139	$ 41,510	10	$ 81,863	71
72	Current Year Purchases	984	98	98		10	98	72
73	Fully Depreciated Assets	642,152				10	642,152	73
74								74
75	TOTALS	$ 866,996	$ 727	$ 42,237	$ 41,510		$ 724,113	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, Ll	2015	$ 5,762	$ 163	$ 163	$	5	$ 5,273	76
77		Allocated from EC Clinical, LLC	2012	2,739	548	548		5	1,905	77
78										78
79										79
80	TOTALS			$ 8,501	$ 711	$ 711	$		$ 7,178	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)	$ 10,350,464	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 392,356	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 458,799	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 66,443	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 4,922,091	85	

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

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

G. Construction-in-Progress

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

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

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

Facility Name & ID Number Lakewood Nursing & Rehab Center, Llc # 0046169 Report Period Beginning: 01/01/15 Ending: 12/31/15

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

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

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5	Storage Unit Rental				2,101			5
6								6
7	TOTAL				$ 2,101 **			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.	/2016	$
13.	/2017	$
14.	/2018	$

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

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO
16. Rental Amount for movable equipment: $ 3,930 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 Nursing & Rehab Center, Llc # 0046169 Report Period Beginning: 01/01/15 Ending: 12/31/15

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 Nursing & Rehab Center, Llc # 0046169 Report Period Beginning: 01/01/15 Ending: 12/31/15

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

		1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff			Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service		Cost	Units	Cost				
1	Licensed Occupational Therapist	39 - 03	hrs		$		$ 557,906	$		$ 557,906	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs				252,983			252,983	2
3	Licensed Recreational Therapist		hrs								3
4	Licensed Physical Therapist	39 - 03	hrs				573,505			573,505	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					557,733		557,733	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						31,444	98,684		130,128	13
14	TOTAL				$		$ 1,415,838	$ 656,417		$ 2,072,255	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.

STATE OF ILLINOIS

Facility Name & ID Number Lakewood Nursing & Rehab Center, Llc **#** 0046169 **Report Period Beginning:** 01/01/15 **Ending:** 12/31/15

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 12/31/15 **(last day of reporting year)**

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 2,954	$ 247,550	1
2	Cash-Patient Deposits	22,144	22,144	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,180,771	1,180,771	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	283,355	283,355	6
7	Other Prepaid Expenses	3,672	3,672	7
8	Accounts Receivable (owners or related parties)	740,936	3,474,450	8
9	Other(specify):	2,477,432	2,477,432	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 4,711,264	$ 7,689,374	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	558,952	5,584,057	15
16	Equipment, at Historical Cost	673,807	673,807	16
17	Accumulated Depreciation (book methods)	(825,000)	(4,719,184)	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):		29,703	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 407,759	$ 5,890,144	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 5,119,023	$ 13,579,518	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 1,872,097	$ 1,872,096	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	18,057	18,057	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	250,662	250,662	30
31	Accrued Taxes Payable (excluding real estate taxes)	13,757	13,757	31
32	Accrued Real Estate Taxes(Sch.IX-B)	109,791	109,791	32
33	Accrued Interest Payable		803,169	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached Schedule	17,444	3,302,716	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 2,281,808	$ 6,370,248	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		7,158,159	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)**	$	$ 7,158,159	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 2,281,808	$ 13,528,407	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 2,837,215	$ 51,111	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 5,119,023	$ 13,579,518	48

***(See instructions.)**

Facility Name & ID Number Lakewood Nursing & Rehab Center, Llc # 0046169 Report Period Beginning: 01/01/15 Ending: 12/31/15

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,853,062	1
2	Restatements (describe):		2
3	**Rounding**	6	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,853,068	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	984,147	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 984,147	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)**	$ 2,837,215	24 *

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

Facility Name & ID Number Lakewood Nursing & Rehab Center, Llc # 0046169 Report Period Beginning: 01/01/15 Ending: 12/31/15

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	$ 12,080,916	1
2	Discounts and Allowances for all Levels	(5,809,262)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 6,271,654	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	5,146,490	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 5,146,490	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	1,200	13
14	Non-Patient Meals	593	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	552,147	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	158,518	19
20	Radiology and X-Ray	66,542	20
21	Other Medical Services	74,268	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 853,268	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	31,112	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 31,112	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	473	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 473	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 12,302,997	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,532,047	31
32	Health Care	4,209,030	32
33	General Administration	2,312,138	33
	B. Capital Expense		
34	Ownership	932,034	34
	C. Ancillary Expense		
35	Special Cost Centers	2,072,255	35
36	Provider Participation Fee	261,346	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 11,318,850	40
41	**Income before Income Taxes (line 30 minus line 40)****	984,147	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 984,147	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 3,692,136	44
45	Private Pay - Net Inpatient Revenue	1,631,515	45
46	Medicare - Net Inpatient Revenue	783,952	46
47	Other-(specify) Hospice	123,912	47
48	Other-(specify) Insurance	40,139	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 6,271,654	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.**

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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	2,046	2,234	$ 101,341	$ 45.36	1
2	Assistant Director of Nursing	1,968	2,167	76,516	35.31	2
3	Registered Nurses	29,320	32,333	1,049,542	32.46	3
4	Licensed Practical Nurses	24,922	27,467	733,924	26.72	4
5	CNAs & Orderlies	78,554	85,680	1,100,691	12.85	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	11,113	12,384	234,919	18.97	8
9	Activity Director	1,840	1,922	36,905	19.20	9
10	Activity Assistants	9,264	10,083	102,523	10.17	10
11	Social Service Workers	8,449	9,243	224,211	24.26	11
12	Dietician					12
13	Food Service Supervisor	1,888	2,067	59,868	28.96	13
14	Head Cook	24	24	473	19.71	14
15	Cook Helpers/Assistants	5,570	6,024	91,131	15.13	15
16	Dishwashers	14,128	15,632	153,584	9.82	16
17	Maintenance Workers	5,772	6,429	131,135	20.40	17
18	Housekeepers	15,386	17,173	184,618	10.75	18
19	Laundry	5,019	5,616	53,802	9.58	19
20	Administrator	2,041	2,201	94,038	42.73	20
21	Assistant Administrator	1,004	1,106	25,590	23.14	21
22	Other Administrative					22
23	Office Manager	1,828	1,847	26,860	14.54	23
24	Clerical	7,175	7,742	151,125	19.52	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	1,955	2,193	50,034	22.82	31
32	Other Health Care(specify)					32
33	Other(specify) See Supplemental	2,248	2,581	38,884	15.07	33
34	TOTAL (lines 1 - 33)	231,514	254,148	$ 4,721,714 *	$ 18.58	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	430	$ 21,787	01-03	35
36	Medical Director	Monthly	26,100	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	8,741	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	430	$ 56,628		49

C. CONTRACT NURSES

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

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Margie Thompson	Administrator	0	$ 94,038
Anna Mohr	Asst. Admin	0	25,590
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 119,628

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
See Attached	Legal	$ 41,973
Frost / Marcum	Accounting	25,749
Personnel Planners	Unemployment Consulting	3,325
Extended Care Consulting	Home Office Expense	348,792
Extended Care Clincial	Home Office Expense	116,268
E-Health Data Solutions	MDS Software	3,180
Achieve	Data Processing	15,587
Pro Payroll Solutions	Payroll Services	24,071
IIT/Sourcetech	Data Processing	495
Ability Network	Medicare Billing	3,586
AIS Assessment & Intelligence	Data Processing	1,319
See Supplemental Schedule		15,934
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 600,280

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 194,403
Unemployment Compensation Insurance	165,783
FICA Taxes	357,736
Employee Health Insurance	102,376
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Physicals	12,842
Other Employee Welfare	8,300
Holiday Expense	4,911
TOTAL (agree to Schedule V, line 22, col.8)	$ 846,351

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

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 1,990
Advertising: Employee Recruitment	22,536
Health Care Worker Background Check	4,368
(Indicate # of checks performed 343)	
Patient Background Checks	
Dues & Subscriptions	18,802
Licenses & Fees	5,354
Allocated from EC Consulting	879
Allocated from EC Clinical	158
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 54,088

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	3,119
Allocated from EC Consulting	302
Allocated from EC Clinical	992
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 4,413

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Lakewood Nursing & Rehab Center, Llc # 0046169 Report Period Beginning: 01/01/15 Ending: 12/31/15

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 Nursing & Rehab Center, Llc **#** 0046169 **Report Period Beginning:** 01/01/15 **Ending:** 12/31/15

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?
If YES, give association name and amount. **ICLTC $18,854 ; Alliance of Healthcare $471**

(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. $ **58,313** 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. $ **261,346**
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 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.